

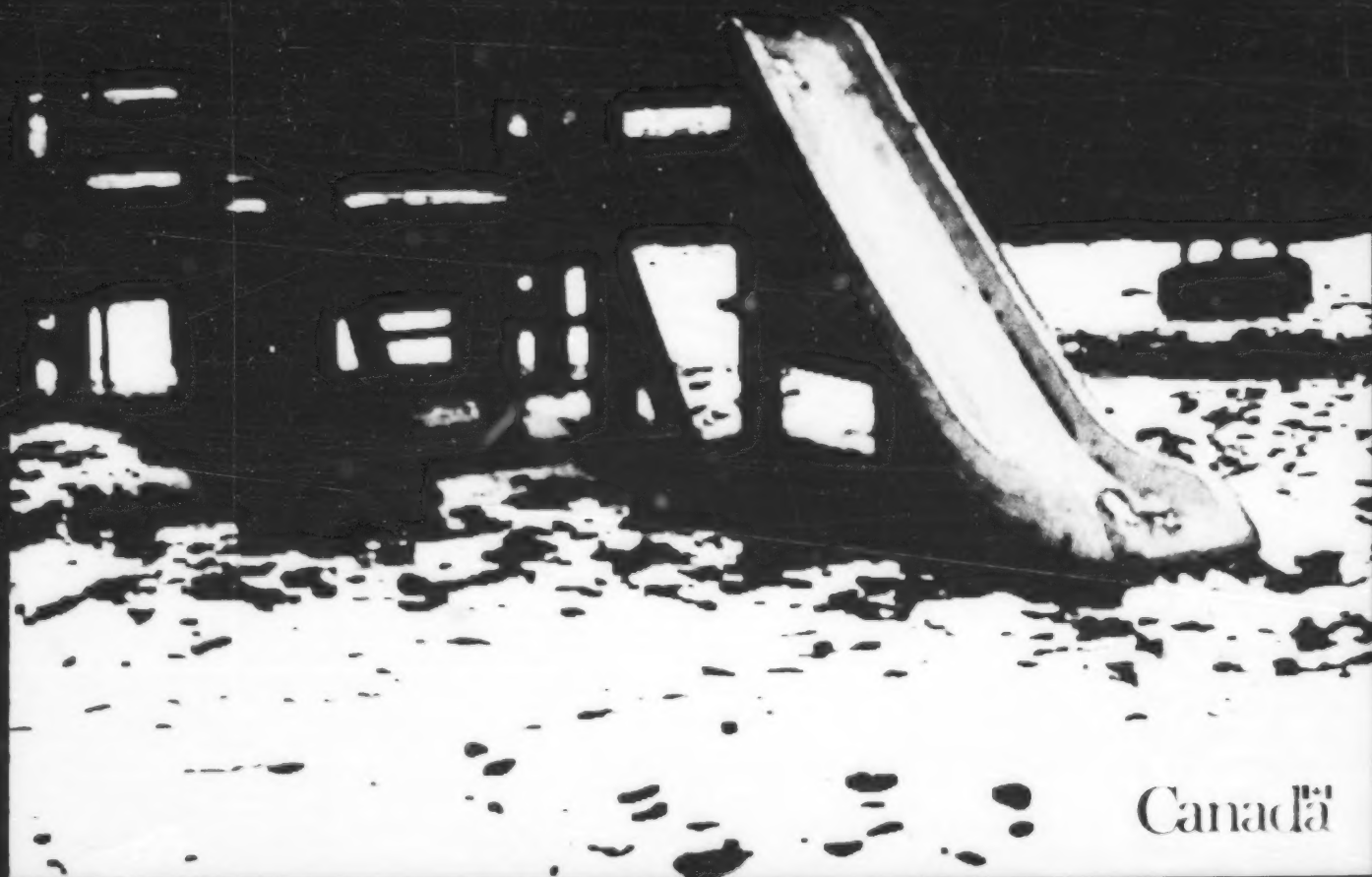


Health
Canada

Santé
Canada

Child Maltreatment in Canada

Canadian
Incidence Study
of Reported Child
Abuse and Neglect
Selected Results



Canada

Our mission is to help the people of Canada
maintain and improve their health.

Health Canada

Copies of this publication are available from the:

National Clearinghouse on Family Violence

Health Canada

A.L. 1907D1

7th Floor, Jeanne Mance Bldg.

Tunney's Pasture

Ottawa, Ontario

K1A 1B4

Telephone: 1-800-267-1291 or (613) 957-2938

Fax: (613) 941-8930

Web Site: www.hc-sc.gc.ca/nc-cn

Également disponible en français sous le titre :

Maltraitance des enfants au Canada : Résultats choisis

tirés de l'Étude canadienne sur l'incidence des signalements

de cas de violence et de négligence envers les enfants

Suggested citation: Trocmé N, Wolfe D. Child Maltreatment in Canada :

Selected Results from the Canadian Incidence Study of Reported Child Abuse

and Neglect. Ottawa, Ontario: Minister of Public Works and Government Services

Canada, 2001.

Published by authority of the Minister of Health.

© Minister of Public Works and Government Services Canada, 2001

Cat. H49-152/2000E

ISBN 0-662-29746-6

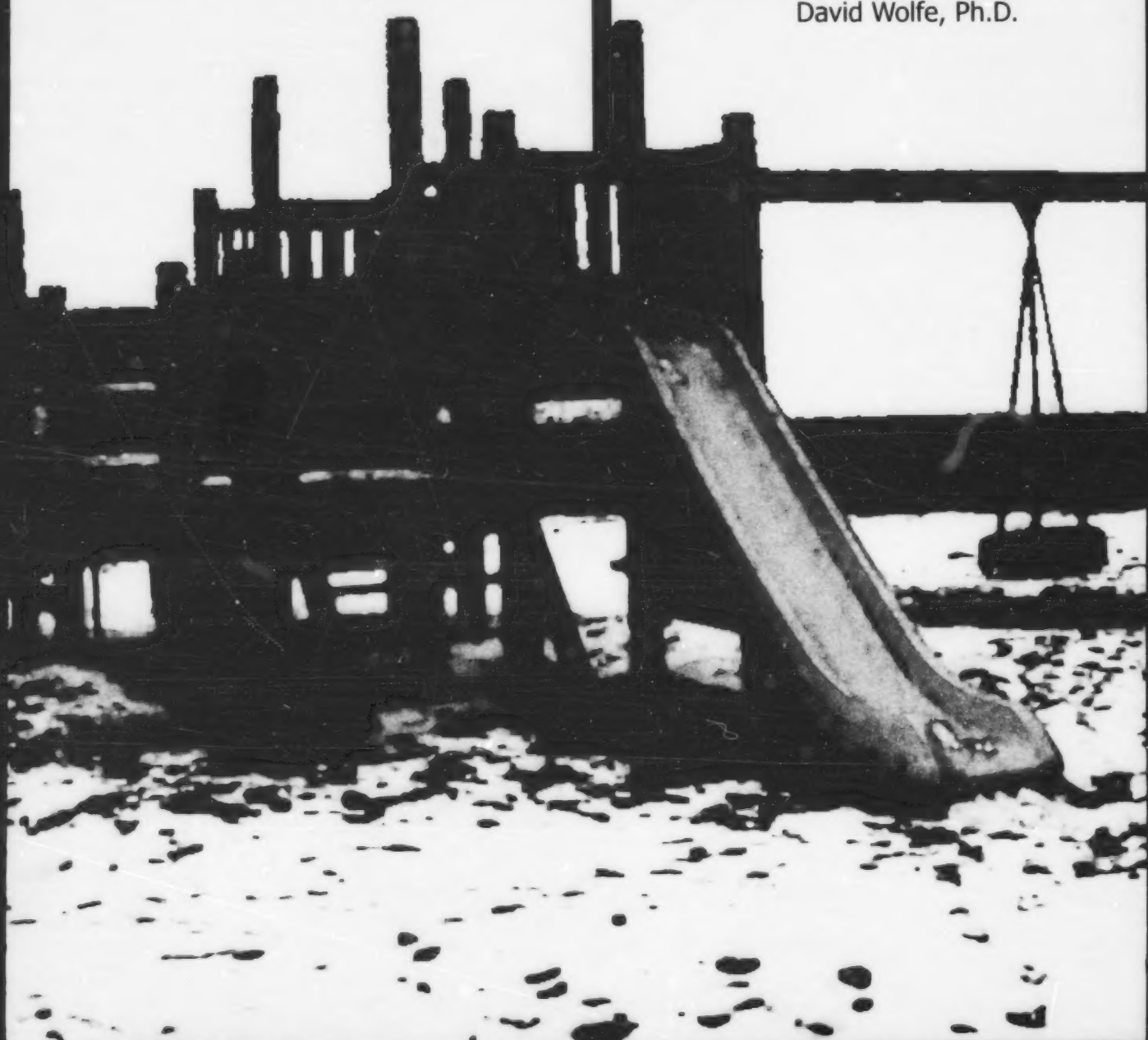


Child Maltreatment in Canada

Canadian
Incidence Study
of Reported Child
Abuse and Neglect

Selected Results

Authored by: Nico Trocmé, Ph.D.
David Wolfe, Ph.D.



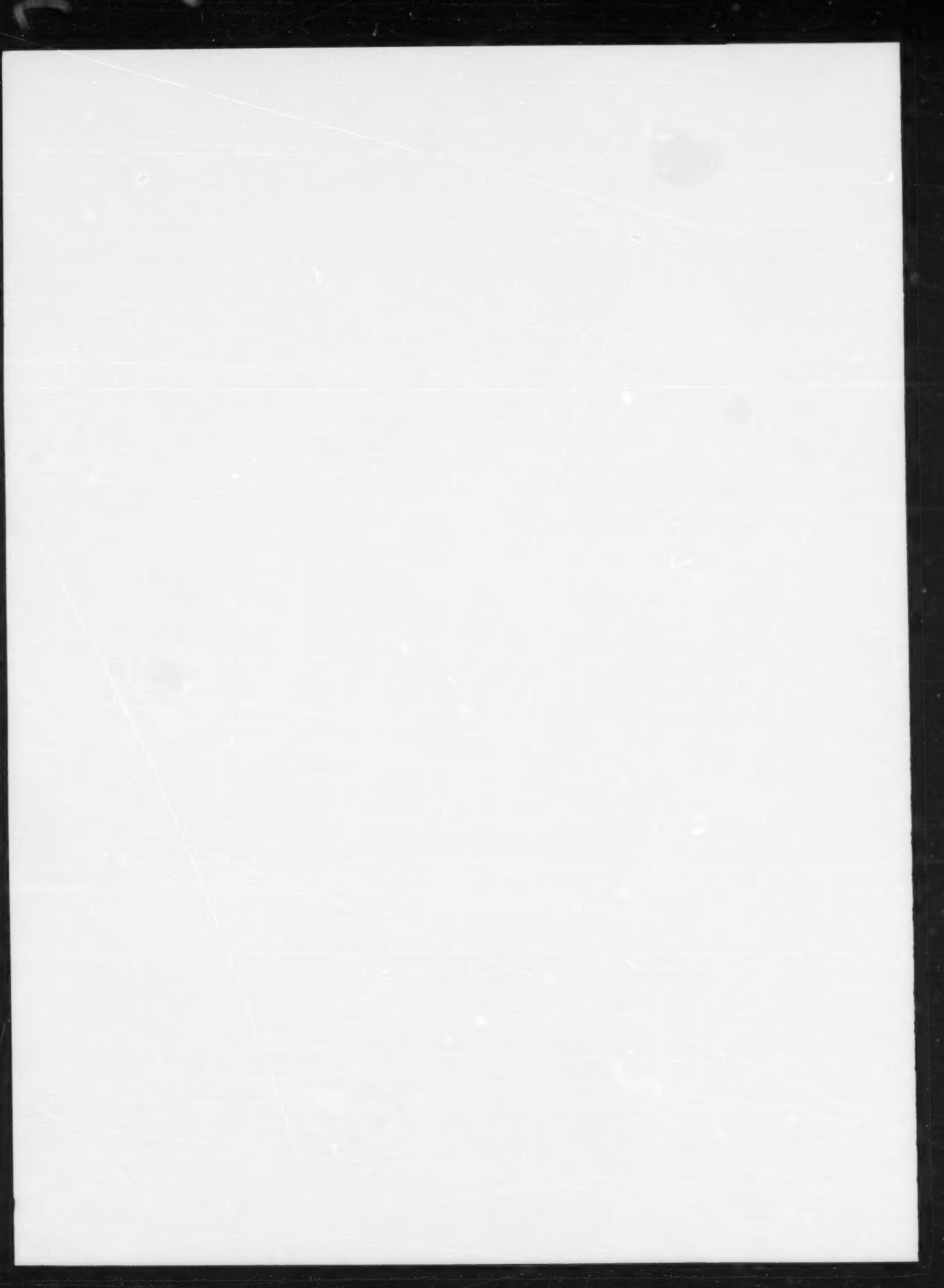


TABLE OF CONTENTS

FOREWORD	1
INTRODUCTION	2
1. STUDY OVERVIEW AND METHODS	5
Background and Objectives	5
Purpose of this Report	6
Definitional Framework for the CIS	6
Methods	7
Scope and Limitations	9
2. CHILD MALTREATMENT IN CANADA: INCIDENCE AND CHARACTERISTICS	11
Total Child Investigations and Overall Rates of Substantiation	11
Categories of Maltreatment	11
Characteristics of Substantiated Maltreatment	16
Summary	21
3. CHILD AND FAMILY CHARACTERISTICS	23
Child Characteristics	23
Family Characteristics	28
Summary	35
4. COMMUNITY RESPONSES TO CHILD MALTREATMENT	36
Source of Referral/Allegation	36
Outcomes of Investigations	39
Summary	43
APPENDICES	
Appendix A: CIS Site Directors/Research Associates	45
Appendix B: National Advisory Committee and Health Canada Staff	48

FOREWORD

At the present time there is no source of comprehensive, reliable national statistics on the nature and extent of child abuse and neglect across Canada. Without this information it has been difficult for policy makers and program developers to know whether the interventions and services currently provided to children and families prevent further abuse and reduce the burden of suffering on those affected. Efforts have been made to address this lack of information. Between 1987 and 1993 a federal/provincial/territorial working group developed a compendium of descriptive information on provincial and territorial child and family services. This working group provided useful general information, but could not give a national picture of the scope and characteristics of child abuse and neglect because of the different ways data are collected across provinces and territories. The Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) is the first Canada-wide effort to begin to fill the gap using a common set of definitions.

It is exciting to have been a part of the development of the CIS since its beginning. So much has happened since 1995, when the

Family Violence Prevention Division of Health Canada funded the Child Welfare League of Canada to convene an expert panel and conduct a feasibility study for a Canadian incidence study of reported child maltreatment. A group of researchers, child welfare directors and other professionals was consulted, and this group strongly recommended that a study be undertaken with a focus on child maltreatment cases reported to child welfare agencies. Health Canada reviewed the feasibility report and provided the funding to initiate the study. A National Advisory Committee was formed to provide guidance and advice as the study unfolded. As well, the Committee heard from youth participants, who provided their perspective on abuse.

The CIS has attracted strong interest and support in every province and territory. It also demonstrates a unique and quite wonderful collaboration of researchers, universities, child welfare practitioners and federal/provincial/territorial governments. Hundreds of people participated. The results will give us a better understanding of the characteristics of children and the environments of their families that may lead to

heightened risk of harm. We will also have more information about community responses to child maltreatment for use in raising awareness of the need for greater prevention efforts and more targeted interventions.

I am grateful to all who participated to make this study a reality. In particular, I would like to thank Dr. Catherine McCourt of the Bureau of Reproductive and Child Health for providing the leadership, Dr. Nico Trocmé and the researchers for their perseverance and dedication to scientific excellence, Gordon Phaneuf and the staff of the Child Maltreatment Division for championing the study and managing the initiative, and the members of the National Advisory Committee, who volunteered many hours of work in spite of very busy personal schedules. Last, I appreciate the thoughtfulness of the youth participants who remind us of why we are collecting these data in the first place — to help us find ways to protect children and prevent maltreatment.

Sandra Scarth
Chair
National Advisory Committee to
the Canadian Incidence Study of
Reported Child Abuse and Neglect

"Inform people of what an overall idea of abuse is. Inform people of how they can get help. Um, to discipline your child you don't need to hit your child. I think that's something that needs to be known and that's something that needs to be put to use, because there's other ways."

Participant in a youth focus group discussing prevention strategies.¹

INTRODUCTION

The Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) is the first national study of the incidence of child abuse and neglect reported to, and investigated by, child welfare services in Canada. This report, *Child Maltreatment in Canada: Selected Results from the Canadian Incidence Study of Reported Child Abuse and Neglect*, contains a descriptive analysis of the findings of the study, with a focus on a subset of the CIS data set — those investigations in which the child maltreatment was substantiated. The full data set, including information about child welfare investigations in which maltreatment was either suspected or unsubstantiated, is described in detail in a companion report, *Canadian Incidence Study of Reported Child Abuse and Neglect: Final Report*.²

Background

Since the mid-1980s there have been calls for better information on the burden of child abuse in Canada. Badgley³ and Rix Rogers,⁴ among others, have made recom-

mendations in this regard. Both Badgley and Rogers recognized that accurate, reliable data on the occurrence of maltreatment were integral to developing the knowledge base for prevention and intervention strategies. The Stockholm World Congress Against the Commercial Sexual Exploitation of Children⁵ called on all of the world's nations to improve the information they gather on this aspect of child sexual abuse.

In 1996, the Bureau of Reproductive and Child Health in the former Laboratory Centre for Disease Control, Health Canada, established the Child Maltreatment Division, to build national capacity in surveillance and epidemiology of child abuse and neglect. This was seen by the Department to be an important initiative that would fill an existing gap, and would complement the Bureau programs on unintentional injury and perinatal health. As a first undertaking, the Child Maltreatment Division proposed to implement a periodic national study of reported child abuse and neglect, building on a

¹ Charles G. *Youth focus group on child abuse and neglect*. Ottawa: Health Canada, unpublished report.

² Trocmé N, MacLaurin B, et al. *Canadian incidence study of reported child abuse and neglect: final report*. Ottawa, Ontario: Minister of Public Works and Government Services Canada, 2001.

³ Badgley R. *Report of the committee on sexual offences against children and youths*. Ottawa: Minister of Supply and Services Canada, 1984.

⁴ Special Advisor to the Minister on Child Sexual Abuse. *Reaching for solutions: the report of the special advisor to the Minister of National Health and Welfare on child sexual abuse in Canada*. Ottawa: Minister of Supply and Services Canada, 1990.

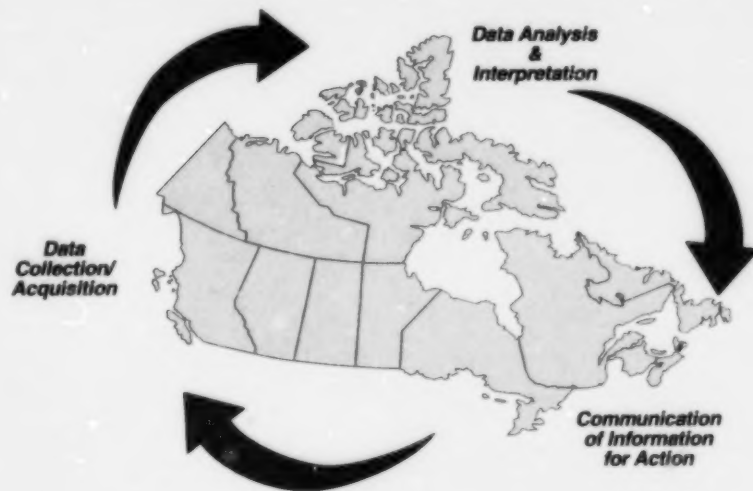
⁵ Muntarbhorn V. *The report of the Rapporteur-General*. Stockholm: World Congress Against Commercial Sexual Exploitation of Children. Stockholm: World Congress Against Commercial Sexual Exploitation of Children, 1996.

1995 feasibility study conducted for the Family Violence Prevention Division in Health Canada.⁶

Departmental consultations with senior provincial/territorial officials, representatives from other federal departments and agencies, native child welfare leaders and representatives of the non-government sector confirmed widespread support for such a national study.

In 1997, a consortium of researchers, led by Dr. Nico Trocmé, Director of the Bell Canada Child Welfare Research Unit at the University of Toronto's Faculty of Social Work, was contracted by Health Canada to conduct the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) (see Appendix A, CIS Site Directors/Research Associates). Four provinces (British Columbia, Ontario, Quebec⁷ and Newfoundland) provided additional funds to expand data collection in their jurisdictions. The Child Maltreatment Division established a multidisciplinary National Advisory Committee for the study, with expertise drawn from many fields, including public health, child advocacy, child welfare

Figure 1
National Child Health Surveillance



Adapted from CDC

including native child welfare, children's mental health, social work and forensic medicine. The National Advisory Committee created four task groups (site recruitment/enrolment, instrument/definitions, sampling and youth involvement) to provide input into specific aspects of the study (see Appendix B for a list of the National Advisory Committee members).

The CIS as a Component of Child Health Surveillance

Health surveillance is a system of ongoing data collection, analysis and reporting. Figure 1 illustrates the cycle of surveillance, adapted from a conceptual framework described by Dr. Brian McCarthy, Centers for Disease Control and Prevention, Atlanta, Georgia.⁸ Health surveillance provides information on trends, patterns

⁶ Trocmé N, Michalski J, et al. *Canadian incidence study of reported child maltreatment: methodology and feasibility review*. Toronto: University of Toronto, Centre for Applied Social Research, Faculty of Social Work, 1995.

⁷ In Quebec, the CIS was harmonized with the parallel Étude sur l'incidence et les caractéristiques des situations d'abus, de négligence, d'abandon et de troubles de comportement sérieux signalées à la Direction de la protection de la jeunesse (DPJ) au Québec (FIQ). For more details refer to CIS Final Report.

⁸ McCarthy B. The risk approach revisited: a critical review of developing country experience and its use in health planning. In: Liljestrand J, Povey WG (eds). *Maternal health care in an international perspective*. Proceedings of the XXII Berzelius Symposium, 1991 May 27-29, Stockholm, Sweden. Sweden: Uppsala University, 1992: 107-24.

and disparities in health outcomes and health determinants (both risk and protective factors).

National child health surveillance provides information necessary for effective priority-setting and policy and program development, implementation and evaluation. It alerts us to new or emerging threats to the health of Canadian children and enables us to monitor progress in combatting known threats. Child health surveillance at the national level also enables us to participate in international efforts to monitor child health, to better understand disparities in health outcomes within Canada and globally, and to identify solutions. Surveillance also helps to identify child health research priorities and assists in the evaluation of the uptake of research evidence.

The CIS is the foundation for a child maltreatment surveillance program as part of comprehensive national child health surveillance. The CIS will be repeated at regular intervals so that secular trends can be analyzed and policy and program interventions evaluated. This study will be complemented by other maltreatment surveillance activities, such as surveillance of fatal child abuse.

The CIS study design reflects the concept of determinants of health: that health status is influenced by many factors including physical and social environments, behaviours and clinical services.⁹ This approach to surveillance of child abuse and neglect is further elaborated in *A Conceptual and Epidemiological Framework for Child Maltreatment Surveillance*.¹⁰

Conclusion

We anticipate that this report will be of interest and use to a wide range of people concerned with children's issues, including health and social policy makers, health, social service, justice and law enforcement professionals, those who advocate on behalf of children, the non-government and research communities, and all citizens concerned about child abuse and neglect.

This document and the companion *Canadian Incidence Study of Reported Child Abuse and Neglect: Final Report* present descriptive statistics from the CIS data set. The CIS methods, and therefore the data, have limitations that are clearly laid out in both reports. The CIS data set will provide opportunities for further analysis

to better understand the scope and characteristics, as well as the risk and protective factors, associated with investigated child maltreatment. Suggested priorities for further analysis are outlined by Dr. Trocmé and colleagues in the *CIS Final Report*.

The CIS demonstrates the importance and value of collaborative work across disciplines and sectors. On behalf of Health Canada, we wish to acknowledge the contributions of the research team, the National Advisory Committee, the provincial and territorial directors of child welfare and their child welfare administrators, and the hundreds of child welfare workers from across the country who provided data for the study. Thank you.

Gordon Phaneuf
Sharon Bartholomew
Lil Tonmyr
Kathleen Moss
Catherine McCourt

Child Maltreatment Division and
Bureau of Reproductive and Child
Health
Centre for Healthy Human
Development
Population and Public Health
Branch
Health Canada

⁹ Federal, Provincial and Territorial Advisory Committee on Population Health. *Strategies for population health: investing in the health of Canadians*. Ottawa: Minister of Supply and Services Canada, 1994.

¹⁰ Health Canada. *A conceptual and epidemiological framework for child maltreatment surveillance*. Ottawa: Minister of Public Works and Government Services Canada, in press.

1. STUDY OVERVIEW AND METHODS

Concerted efforts to understand the causes and consequences of child maltreatment have led to significant gains in knowledge and resources, while at the same time pointing out the complex nature and unknown elements of the problem. It is widely accepted today, for example, that the context of child maltreatment includes societal, cultural, and socioeconomic factors, as well as those closest to the child's social world — the parent-child relationship and the family.

This report highlights major descriptive findings from the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS). The CIS is the first nationwide study to examine the incidence of reported child maltreatment and the characteristics of the children and families investigated by Canadian child welfare services. The incidence estimates presented in this report are based on a survey, completed by child welfare workers, of a representative sample of 7,672 child maltreatment investigations.

This chapter presents the rationale, objectives, and methodology of the study and the approach of this report. The reader is referred to a companion document, the *Canadian Incidence Study of Reported Child Abuse and Neglect: Final Report*, for additional details, a full description of the

methodology, and more complete findings from the study.

Background and Objectives

There is currently no source of comprehensive, Canada-wide data on children and families investigated because of suspected child abuse or neglect. In Canada, most child abuse and neglect statistics are kept on a provincial or territorial basis. Because of differences both in definitions of maltreatment and methods of counting cases, it is not possible to aggregate provincial and territorial statistics. The lack of national data has hampered the ability of governments and social service providers to develop national and regional policies and programs that effectively address the needs of maltreated children. National data are also needed to provide a meaningful context for interpreting findings from Canadian and international child maltreatment research.

Recognizing the need for better national child maltreatment information, Health Canada, through the Child Maltreatment Division of the Bureau of Reproductive and Child Health, provided funding for a national incidence study — the CIS. Four provinces provided additional funds to expand data collection in their jurisdictions.

The CIS selected a representative sample of Canadian child welfare offices and used a standardized data collection form to gather information on investigated children and their families directly from child welfare investigators. The primary objective of the study was to provide reliable estimates of the scope and characteristics of reported child abuse and neglect across Canada. Specifically, the study was designed to

- examine the rates of physical abuse, sexual abuse, neglect, and emotional maltreatment, as well as multiple forms of maltreatment, reported to, and investigated by, child welfare services;
- examine the severity of maltreatment in terms of chronicity and evidence of harm/risk;
- examine selected determinants of health for investigated children and their families; and
- monitor short-term investigation outcomes, including substantiation rates, placement in care, use of child welfare court, and criminal prosecution.

The CIS was designed to be national in scope, and to involve collaboration with all provincial and territorial governments. The results will be used to assist in allocation of resources to prevent and respond to child maltreatment; to increase understanding of the interface of child maltreatment and health determinants; and to guide further research in the field.

Purpose of this Report

Child Maltreatment in Canada:

Selected Results from the CIS presents the major descriptive findings¹¹ of the CIS. The national estimates are based on a core sample of 7,672 child maltreatment investigations, drawn from a total population of an estimated 135,573 child maltreatment investigations by child welfare services in 1998.

This report contains less detail than the *CIS Final Report*, in order to facilitate interpretation of the major findings and descriptions of child maltreatment. The report limits itself to substantiated cases only rather than providing information on all investigations (a description of the three levels of substantiation — suspected, substantiated, and unsubstantiated — is provided in the following section).¹² Although conservative, analysis of only substantiated cases provides a more standard comparison for drawing conclusions about the characteristics and outcomes of child maltreatment. Readers interested in information about all

investigated reports of maltreatment are referred to the *CIS Final Report*.

This report is also guided by the Conceptual and Epidemiological Framework for Child Maltreatment Surveillance, which was developed in concert with the CIS to guide Health Canada in surveillance of key factors associated with the incidence and prevalence of child maltreatment.¹³ The conceptual framework identifies key surveillance factors at each level of population health: individual (including adults and children), family, community, and society. These factors reflect the major determinants of health as they relate to the field of child maltreatment.

Definitional Framework for the CIS

Statistics on child abuse and neglect are collected and reported in very different ways.¹⁴ Confusion can easily arise because of variations in the way a particular statistic is calculated. The following discussion and framework are provided

to assist readers in interpreting the statistics included in this report.

The CIS definition of child maltreatment includes 22 forms of maltreatment subsumed under four categories: physical abuse, sexual abuse, neglect, and emotional maltreatment. This classification reflects a fairly broad definition of child maltreatment, and includes several forms that are not specifically included in some provincial and territorial child welfare statutes (e.g., educational neglect and exposure to family violence).

The 22 forms of maltreatment tracked by the CIS are defined in the detailed sections on the four categories of maltreatment in Chapter 2.

Following each investigation of a report of child maltreatment, the worker rated the outcome of the investigation in terms of three levels of substantiation: unsubstantiated, suspected, and substantiated. The following definition of substantiation was used:

¹¹ The descriptive findings do not include statistical analyses of differences between subgroups.

¹² The following formula was applied to data from the Final Report to derive the subsample of substantiated cases for this report: (a) the raw estimate in each column in a table was multiplied by the percentage of cases that were substantiated; if the raw estimate was too low to provide a breakdown by level of substantiation, the overall substantiation rate was used (physical abuse, 34%; sexual abuse, 38%; neglect, 43%; emotional maltreatment, 54%); (b) this new raw estimate of substantiated cases was added across the rows in each table to obtain a total number for each row and column; (c) new percentages were derived for each variable, based on these adjusted raw estimates of substantiated cases for the four categories of maltreatment.

¹³ Health Canada. *A conceptual and epidemiological framework for child maltreatment surveillance*. Ottawa: Minister of Public Works and Government Services Canada, in press.

¹⁴ Trocmé ND, McPhee D, et al. *Ontario incidence study of reported child abuse and neglect*. Toronto: Institute for the Prevention of Child Abuse, 1994.

A case is considered substantiated if it is the worker's professional opinion that the balance of evidence indicates that abuse or neglect has occurred. The term is synonymous with the terms "verified" or "confirmed", which are used in some jurisdictions.

A case is suspected if there is not enough evidence to substantiate maltreatment, but there nevertheless remains a suspicion that maltreatment may have occurred.

A case is unsubstantiated if there is sufficient evidence to conclude that the child has not been maltreated.

Unsubstantiated does not mean that a referral was inappropriate or malicious; it simply indicates that the investigating worker determined that the child had not been maltreated (additional information on Malicious Referrals is provided in the *CIS Final Report*).

Methods

The CIS is the first national study examining the incidence of reported child abuse and neglect in Canada. The CIS captured information about children and their families as they came into contact with child welfare services over a 3-month sampling period from October 1 to December 31, 1998. Maltreated children who were not reported to child welfare services, screened-out uninvestigated reports, and new allegations on cases currently open at the time

of data collection were not included in the CIS.

Sampling

A multi-stage sampling design was used, first to select a representative sample of child welfare offices across Canada, and then to sample cases within these offices. Information was collected directly from the investigating child welfare workers. Fifty-one sites were selected from a pool of 327 child welfare service areas in Canada (Figure 1-1). Five sites declined to be involved because of their particular circumstances, and five replacement sites were randomly selected from the remaining pool.

All but four sites were randomly selected from their respective strata. One of the three aboriginal sites joined the study after the initial sample had been drawn. The three sites from the northern territories were selected on the basis of accessibility and expected case volume. In total, these sites provided information on 7,672 child investigations, which were used to derive national estimates of the annual rate and characteristics of investigated child maltreatment in Canada.

National Consultation

Extensive consultations with provincial/territorial child welfare officials and professionals drawn from a range of disciplines were conducted by Health Canada to

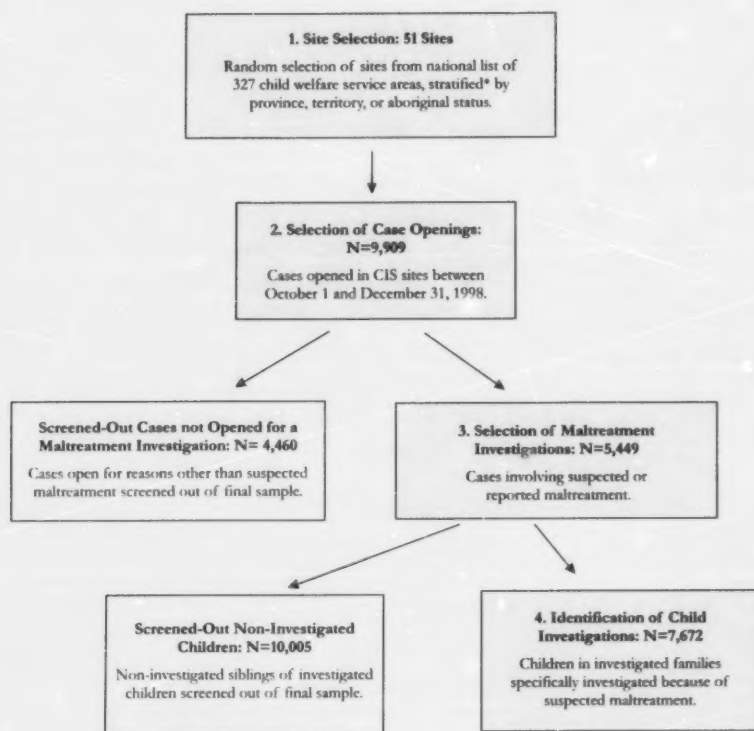
garner insights into, and support for, the development of the study. The Child Maltreatment Division established a multidisciplinary National Advisory Committee for the CIS that included representatives from public health, child advocacy, child welfare (including native child welfare), children's mental health, social work and forensic medicine. Committee members contributed to the study design and implementation in several critical aspects, such as recruitment of participating sites, design of the data collection instrument, and involvement of youth in providing their perspective.

Assessment Form

The main data collection instrument used for the study was the Maltreatment Assessment Form, which was completed by the primary investigating child welfare worker upon completion of a child welfare investigation. The Maltreatment Assessment Form consisted of an Intake Face Sheet, a Household Sheet, and a Child Sheet.

The Intake Face Sheet asked the workers to provide basic information about the report or referral, as well as information about the child(ren) involved. The form requested information on the date of referral, referral source, number of children in the home under the age of 19, age and sex of the children, whether there was

Figure 1-1
Canadian Incidence Study of Reported Child Abuse and Neglect:
Sampling Stages in 1998



* Child welfare service areas were further stratified by region and/or size in Newfoundland, Quebec, Ontario and British Columbia.

suspected or alleged maltreatment, whether the case was screened out, the family's postal code, and the reason for the referral or screening out. No directly identifying information was collected. If abuse or

neglect was suspected, either by the person(s) making the report or by the investigating worker at any point in the investigation, then the remainder of the form was completed.¹⁵

The Household Sheet was completed only when at least one child in the family was investigated for maltreatment. The household was defined as all the adults living at the address of the investigation. The Household Sheet collected detailed information on up to two caregivers, including their relationship to the child, gender, age, income source and level, educational level, ethno-cultural origin, and information on selected determinants of health. Descriptive information was requested on the contact with the caregiver, caregiver's own history of abuse, other adults in the home, housing accommodations, caregiver functioning, case status, and referral(s) to other services.

The Child Sheet was completed for each child who was investigated for maltreatment. The Child Sheet documented up to three different forms of maltreatment, and included levels of substantiation, alleged perpetrator(s), and duration of maltreatment. The workers were asked to indicate the form of maltreatment that best categorized the investigation (the primary form). In addition, the Child Sheet collected information on child functioning, physical and emotional harm to the child (attributable to the alleged child maltreatment), child welfare court activity, out-of-

¹⁵ The CIS Guide Book and training sessions emphasized that workers should base their responses to these questions on their clinical expertise rather than simply transposing information collected on the basis of provincial or local investigation standards. The Guide Book specifies the following: "Indicate those children who were a subject of child welfare investigation. Given the variety in definition and practice across Canada, rely on your clinical judgment to identify cases where maltreatment was actually suspected."

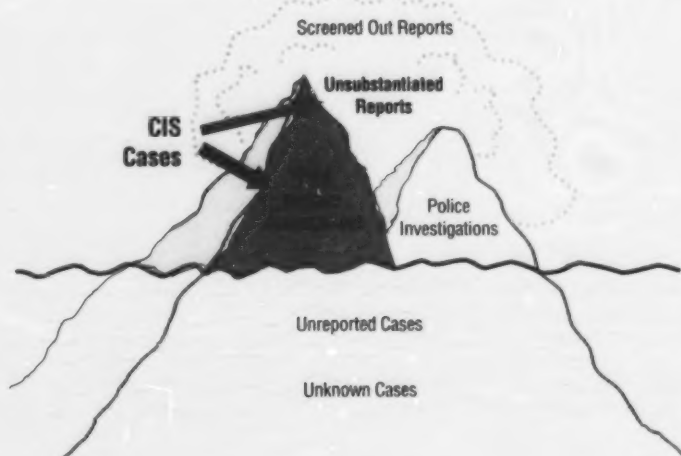
home placement, police involvement, and the caregiver's response to suspected or substantiated sexual abuse.

A significant challenge for the study was to overcome the variations in the definitions of maltreatment used by different jurisdictions. Rather than anchor the definitions in specific legal or administrative definitions, a single set of definitions corresponding to standard research classification schemes was used. All items on the data collection forms were defined in the accompanying CIS Guide Book.

Scope and Limitations

It is important to emphasize that the CIS is a study of child maltreatment *reported to, and investigated by*, child welfare agencies in Canada. Reports of child abuse and neglect that are screened out (i.e. not investigated) by child welfare are not included in this study, nor is child maltreatment reported to police but not to child welfare. Child abuse and neglect that come to the attention of other professionals but are not reported to child welfare services are not counted in the CIS. Finally, the CIS does not include unidentified child maltreatment, i.e. those cases in which the child's situation is unknown to the community and

Figure 1-2
Scope of CIS*



* Adapted from Trocmé N, McPhee D et al. *Ontario incidence study of reported child abuse and neglect*. Toronto, ON: Institute for the Prevention of Child Abuse, 1994; and, Sedlak AJ, Broadhurst DD. *Executive summary of the third national incidence study of child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services, 1996.

Source: CIS Final Report

its structures and services. Figure 1-2 depicts the scope of the CIS in relation to the occurrence of child maltreatment in Canada.

Within the scope of the CIS, the study has limitations of which the reader should be aware. First, reporting of child maltreatment, while required by law in all provinces and territories, is nevertheless subject to different levels of community awareness, reporting bias, and professional training. For example, in communities that have initiated efforts to draw awareness to child maltreatment, and among professions that have added specific training and awareness protocols for students and practitioners,

there are likely to be more referrals than where such efforts are lacking. Without such initiatives, professionals and non-professionals may be less inclined to report suspected maltreatment that does not involve clear physical injuries or similar evidence (such as neglect and emotional maltreatment). Although the majority of professionals report their suspicions of maltreatment without hesitation, some may be less likely to do so given previous experiences with the system or their belief that they can find better options in the best interest of the child.¹⁶

Second, the data collected for the CIS were weighted to derive

¹⁶ Loo SK, Bala NMC, Clark ME, Hornick JP. *Child abuse: reporting and classification in health care settings*. Ottawa: Health Canada, 1998.

national annual incidence estimates. The annualization weights were derived by taking the ratio of cases sampled over the 3-month period of the study (October 1 to December 31, 1998) to the total number of cases opened by each site in 1998 (see *CIS Final Report* for details). While this annualization method provides an accurate estimate of overall volume, it cannot account for qualitative differences in the types of cases referred at different times of the year. For example, some forms of maltreatment that may be extremely important but occur

infrequently, such as child abuse and neglect fatalities, may be under-estimated.

Third, the CIS provides estimates of the number of *investigations* of child maltreatment, rather than the number of children being maltreated. The unit of observation is the child investigation. Some investigations by child welfare will involve children who were previously investigated in the same year. Although multiple investigations of the same child were removed from the data for the CIS 3-month sample, it was

not possible to do the same in the derivation of annual incidence estimates.

Finally, the sample is not large enough to permit inter-provincial/territorial comparisons across all jurisdictions. Although the sampling method does allow for reliable and valid national estimates of child maltreatment (within the constraints noted here and discussed more fully in the *CIS Final Report*), no attempt was made to draw comparisons between regions of the country.

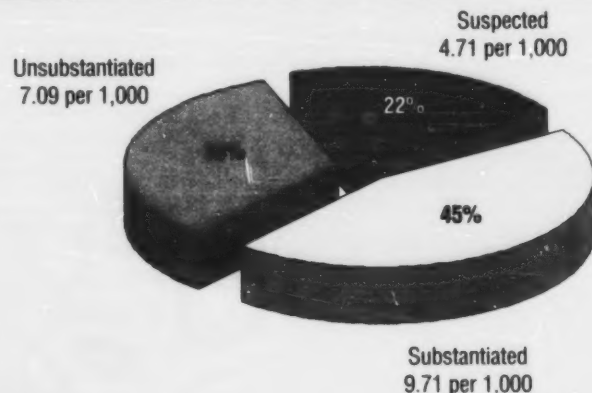
2. CHILD MALTREATMENT IN CANADA: INCIDENCE AND CHARACTERISTICS

This chapter presents estimates of the number of child maltreatment investigations conducted in Canada during 1998. To aid the reader, the data are first presented in terms of the estimated total number of child investigations, as well as the annual incidence rate calculated per 1,000 children aged 0 to 15 years. These figures refer to child investigations, not to the number of investigated families. Thus, if several children in a family had each been reported as abused or neglected, each investigated child counted as a separate child investigation. Investigations of individual categories of maltreatment (physical and sexual abuse, neglect, and emotional maltreatment) are first described, followed by information on the characteristics of substantiated cases.

Total Child Investigations and Overall Rates of Substantiation

An estimated 135,573 child maltreatment investigations were conducted in Canada in 1998. This figure corresponds to an estimated incidence rate of 21.52 investigations per 1,000 children. It is important to keep in mind, however, that this incidence rate includes *all*

Figure 2-1
Child Maltreatment Investigations by Level of Substantiation



Source: CIS Final Report, Table 3-1

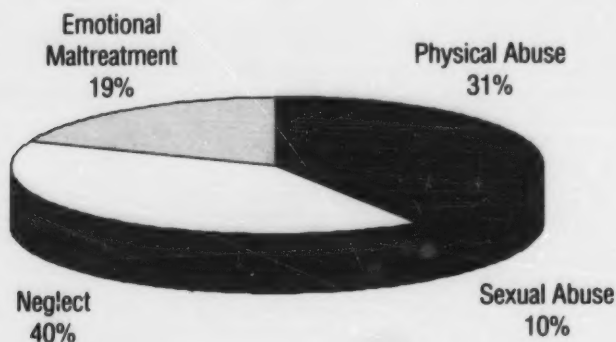
child maltreatment investigations, regardless of whether the report was substantiated or not.

Figure 2-1 shows that almost half (45%) of these reports were substantiated by the investigating worker. The remaining investigations either had insufficient information to substantiate, but the worker maintained suspicion that maltreatment had occurred (22%), or the worker determined on the basis of the investigation that the child had not been maltreated (33%). Of the estimated 21.52 investigations per 1,000 children in Canada in 1998, an estimated 9.71 per 1,000 were substantiated, 4.71 per 1,000 were suspected, and 7.09 per 1,000 were unsubstantiated.

Categories of Maltreatment

The primary reason for child maltreatment investigations is shown in Figure 2-2. Child neglect was the most common reason for investigation (40% of all investigations), followed by physical abuse (31%), emotional maltreatment (19%), and sexual abuse (10%). The substantiation rate for emotional maltreatment as the primary reason for investigation was highest of all four categories of maltreatment (54% substantiated), whereas the other three categories had similar levels of substantiation (physical abuse: 34%, sexual abuse: 38%, neglect: 43%).

Figure 2-2
Primary Reason for Investigation



Source: CIS Final Report, Table 3-3

For physical abuse as the primary reason for investigation, the incidence rate of substantiated cases was an estimated 2.25 per 1,000 children in 1998. Sexual abuse, as the primary reason for investigation, was substantiated in 0.86 cases per 1,000 children, while neglect, as the primary reason for investigation, was substantiated in 3.66 cases per 1,000 children in 1998. Finally, for emotional maltreatment as the primary reason for investigation, the incidence rate of substantiated cases was 2.20 per 1,000 children in 1998. These four rates add up to an estimated 8.97 cases per 1,000 children in which the primary reason for investigation was substantiated. The difference between 9.71 per 1,000 (the overall incidence of substantiated

investigations) and 8.97 per 1,000 — 0.74 per 1,000 — is accounted for by those cases in which a form of maltreatment other than the primary reason for investigation was substantiated.¹⁷

We now turn to substantiated cases of specific categories of maltreatment, and look at the characteristics of each.

Physical Abuse

Physical abuse is the deliberate application of force to any part of a child's body, which results or may result in a non-accidental injury. It may involve hitting a child a single time, or it may involve a pattern of incidents. Physical abuse also includes behaviour such as shaking, choking, biting, kicking, burning

or poisoning a child, holding a child under water, or any other harmful or dangerous use of force or restraint. Child physical abuse is usually connected to physical punishment or is confused with child discipline.

For the purposes of the CIS, cases of investigated maltreatment were classified as physical abuse if the investigated child was thought to have suffered, or to be at substantial risk of suffering, physical harm at the hands of the alleged perpetrator. The physical abuse category includes three subtypes or forms of abuse:

Shaken Baby Syndrome:

Brain or neck injuries have resulted from the infant being shaken.

Inappropriate Punishment:

Child abuse has occurred as a result of inappropriate punishment (e.g. hitting with hand or object) that has led to physical harm, or put the child at substantial risk of harm. The judgment of appropriateness is based on many factors, including the severity of harm or potential harm, the amount of force used, the type of punishment relative to the age of the child, and the frequency of punishment. The distinction between this category and "other physical abuse" is that in the former the abusive act is performed within a context of

¹⁷ The substantiation decision is specific to the form of maltreatment being investigated. Given that investigations can involve up to three forms of maltreatment, some investigations can result in substantiation of one form but not of another. For example, an investigation may conclude that a particular child was not sexually abused, yet a severe lack of supervision took place, and therefore concerns about neglect were substantiated.

punishment, whereas in the latter there is no clear punitive or corrective context.

Other Physical Abuse: Any other form of physical brutality that is inflicted on a child, such as intentionally burning a child or hitting the child with a fist.

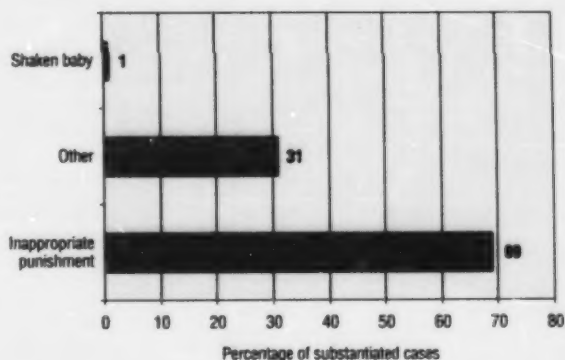
Figure 2-3 shows that the majority (69%) of the substantiated investigations of physical abuse involved inappropriate punishment, although other more severe forms of abuse accounted for almost one-third (31%). Shaken Baby Syndrome, in contrast, accounted for approximately 1% of the substantiated investigations.

Sexual Abuse

Sexual abuse occurs when a child is used for sexual purposes by an adult or youth. Sexual abuse includes fondling a child's genitals, intercourse, incest, rape, sodomy, exhibitionism, and commercial exploitation through prostitution or the production of pornographic materials.

The CIS tracked seven forms or subtypes of sexual abuse, ranging from sexual activity to sexual harassment. If more than one form of sexual abuse was reported for the same incident, workers were asked to identify the most intrusive form. The CIS documented only those cases reported to, and investigated by, child welfare services: many cases of child sexual abuse that do not involve parents or relatives in the

Figure 2-3
Forms of Substantiated Physical Abuse



Percentages do not add up to 100% because of multiple responses.

Source: CIS Final Report, Table 3-5

home are investigated only by the police. Child welfare services usually become involved in extra-familial sexual abuse cases only if there are concerns about the parents' ability to protect the child.

The seven forms of sexual abuse include the following:

Sexual Activity Completed: Included oral, vaginal, or anal sexual activities.

Sexual Activity Attempted: Included attempts to have oral, vaginal, or anal sex.

Touching/Fondling Genitals: Sexual activity involved touching/fondling genitals.

Adult Exposing Genitals to Child: Sexual activity consisted of exposure of genitals.

Sexual Exploitation — Involved in Prostitution or Pornography: Included situations in which an adult sexually exploited a child for

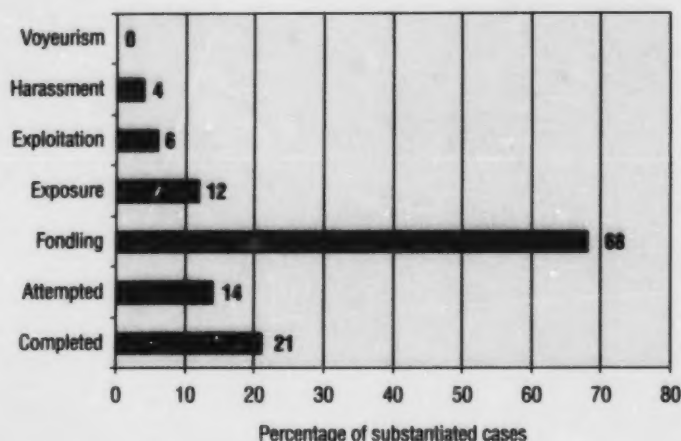
purposes of financial gain or other profit.

Sexual Harassment: Included proposition, encouragement, or suggestion of a sexual nature.

Voyeurism: Included activities in which a child was encouraged to exhibit himself/herself for the sexual gratification of the alleged perpetrator. The "Sexual Exploitation/Pornography" code was used if voyeurism included pornographic activities.

As shown in Figure 2-4, touching and fondling of the genitals was the most common form of substantiated child sexual abuse (68% of cases). Attempted and completed intercourse together accounted for over one-third (35%) of all substantiated investigations, and an adult exposing genitals to a child accounted for 12%. Sexual harassment and sexual exploitation were less common, and the number of cases of voyeurism was insufficient

Figure 2-4
Forms of Substantiated Sexual Abuse



Source: CIS Final Report, Table 3-6

to permit reliable estimates of that particular form of sexual abuse. Please note that because multiple forms of sexual abuse were sometimes reported, the individual subtypes add up to more than 100%.

Neglect

Child neglect occurs when a child's parents or other caregivers are not providing the requisites of a child's emotional, psychological, and physical development. Physical neglect occurs when a child's needs for food, clothing, shelter, cleanliness, medical care and protection from harm are not adequately met. Emotional neglect occurs when a child's need to feel loved, wanted, safe, and worthy is not met. Emotional neglect can range from cases in which the caregiver is simply unavailable, to cases in which the caregiver openly rejects the child.

Although a case of physical assault is more likely to come to the attention of public authorities, neglect can represent an equally serious risk to a child.

Unlike abuse, which is usually incident-specific, neglect often involves chronic situations that are not as easily identified as specific incidents. Nevertheless, all provincial and territorial child welfare statutes include neglect or some type of reference to acts of omission, such as failure to supervise or protect, as grounds for investigating maltreatment. The CIS includes eight subtypes or forms of neglect:

Failure to Supervise or Protect Leading to Physical Harm: The child suffered or was at substantial risk of suffering physical harm

because of the caregiver's failure to supervise and protect the child adequately. Failure to protect included situations in which a child was harmed or endangered as a result of a caregiver's actions (e.g. drunk driving with a child, or engaging in dangerous criminal activities with a child).

Failure to Supervise or Protect Leading to Sexual Abuse: The child has been or was at substantial risk of being sexually molested or sexually exploited, and the caregiver knew or should have known of the possibility of sexual molestation and failed to protect the child adequately.

Physical Neglect: The child has suffered or was at substantial risk of suffering physical harm caused by the caregiver's failure to care and provide for the child adequately. This includes inadequate nutrition/clothing and unhygienic, dangerous living conditions. There must be evidence or suspicion that the caregiver is at least partially responsible for the situation.

Medical Neglect: The child required medical treatment to cure, prevent, or alleviate physical harm or suffering, and the child's caregiver did not provide, refused, or was unavailable or unable to consent to the treatment.

Failure to Provide Treatment for Mental, Emotional or Developmental Problem: The child was at substantial risk of suffering from emotional harm as demonstrated by severe anxiety, depression, withdrawal, self-destructive or aggressive behaviour, or suffering from a

mental, emotional, or developmental condition that could seriously impair the child's development. The child's caregiver did not provide, or refused, or was unavailable or unable to consent to treatment to remedy or alleviate the harm. This category includes failing to provide treatment for school-related problems such as learning and behaviour problems, as well as treatment for infant development problems such as non-organic failure to thrive. This form does not include failure to provide treatment for criminal behaviour (see Permitting Maladaptive/Criminal Behaviour).

Permitting Maladaptive/Criminal Behaviour: A child has committed a criminal offence with the encouragement of the child's caregiver, or because of the caregiver's failure or inability to supervise the child adequately. Alternatively, services or treatment were necessary to prevent a recurrence and the child's caregiver did not provide, refused, or was unavailable or unable to consent to those services or treatment. There is some overlap between this form of neglect and both the failure to supervise form, and the failure to provide treatment form. If a situation involved both criminal activity and some kind of harm or substantial risk of harm to the child, both forms of maltreatment were included.

Abandonment/Refusal of Custody: The child's caregiver has died or was unable to exercise custodial rights and

did not make adequate provisions for care and custody, or the child was in a placement and the caregiver refused or was unable to take custody.

Educational Neglect:

Caregivers knowingly allowed chronic truancy (five or more days a month), failed to enroll the child, or repeatedly kept the child at home. If the child had been experiencing mental, emotional, or developmental problems associated with school, and treatment had been offered but caregivers did not co-operate with treatment, the case was classified as failure to provide treatment.

Child neglect was the most frequently investigated category of maltreatment, and had the second highest rate of substantiation. As shown in Figure 2-5, neglect primarily involved failure to supervise the child properly, which led to physical harm (48%). Parents' reported failure to adequately meet the physical needs of children (physical neglect) accounted for the next largest percentage of substantiated reports (19%), followed by permitting criminal behaviour (14%), abandonment (12%), and educational neglect (11%). Medical neglect and failure to provide necessary treatment for a child were less commonly reported. Again, because of multiple forms of neglect reported, the individual subtypes add up to more than 100%.

Emotional Maltreatment

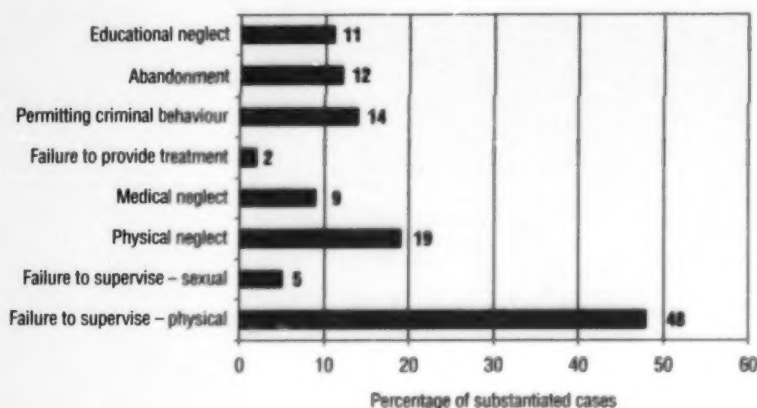
Emotional maltreatment harms a child's sense of self, and involves acts or omissions by the parent or caregiver that have caused, or could cause, serious behavioural, cognitive, emotional, or mental disorders. Examples of emotional maltreatment include verbal threats and put-downs, forcing a child into social isolation, intimidating, exploiting, terrorizing or routinely making unreasonable demands on a child. Emotional maltreatment typically has been a difficult form of maltreatment to define, because it often does not involve a specific incident or visible injury. In addition, its effects, although often severe, may not become apparent until later on in the child's development. Four forms of emotional maltreatment were tracked by the CIS:

Emotional Abuse: The child has suffered or was at substantial risk of suffering from mental, emotional, or developmental problems caused by overtly hostile, punitive treatment, or habitual or extreme verbal abuse (threatening, belittling, etc.).¹⁸

Non-organic Failure to Thrive: A child under 3 years has suffered a marked retardation or cessation of growth for which no organic reason can be identified. Failure to thrive cases in which inadequate nutrition is the identified cause were classified as physical neglect. Non-organic failure to thrive is

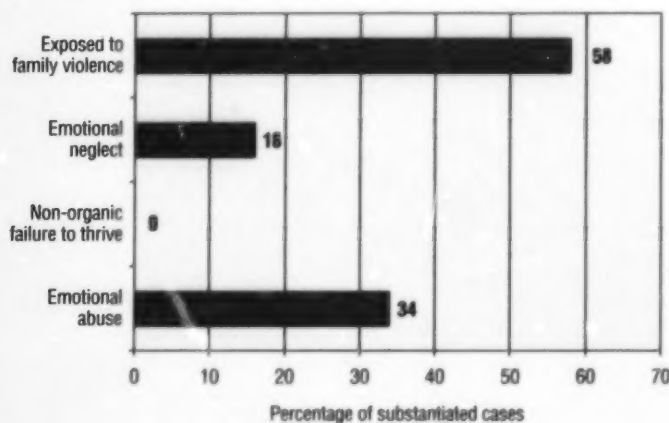
¹⁸ Instances in which children were displaying severe emotional problems requiring treatment and parents refused or did not cooperate with offered treatment were classified as neglect cases under failure to provide treatment.

Figure 2-5
Forms of Substantiated Neglect



Source: CIS Final Report, Table 3-7

Figure 2-6
Forms of Substantiated Emotional Maltreatment



Source: CIS Final Report, Table 3-8

generally considered to be a form of emotional neglect; it has been classified as a separate form of emotional maltreatment because of its particular characteristics.

Emotional Neglect: The child has suffered or is at

substantial risk of suffering from mental, emotional, or developmental problems caused by inadequate nurturance/affection.

Exposed to Family Violence: A child has been a witness to, or involved with, family

violence within his/her home environment. This includes situations in which the child indirectly witnessed the violence (e.g. saw the physical injuries on his/her caregiver the next day).

Figure 2-6 reveals that children's exposure to family violence was the most common form of emotional maltreatment, accounting for well over half (58%) of the substantiated cases. Emotional abuse (34%) and emotional neglect (16%) were also fairly common, whereas non-organic failure to thrive occurred too infrequently to be estimated. Because multiple forms of emotional maltreatment were sometimes reported, the individual forms add up to more than 100%.

Characteristics of Substantiated Maltreatment

Child maltreatment appears in many different forms, and is seldom caused by a single factor. Significantly, maltreatment emerges within the context of a troubled family or individual, who is often facing considerable stress from factors both within and outside of the family. Numerous risk factors, ranging from financial difficulties to limited community resources, increase the likelihood that a given individual will resort to harmful childrearing methods. Yet, these same risk factors are often shared by other families who

do not harm their children, despite high levels of stress. This latter finding underscores the fact that child maltreatment typically results from the interaction of individual, familial, and cultural influences, many of which are documented by the CIS.

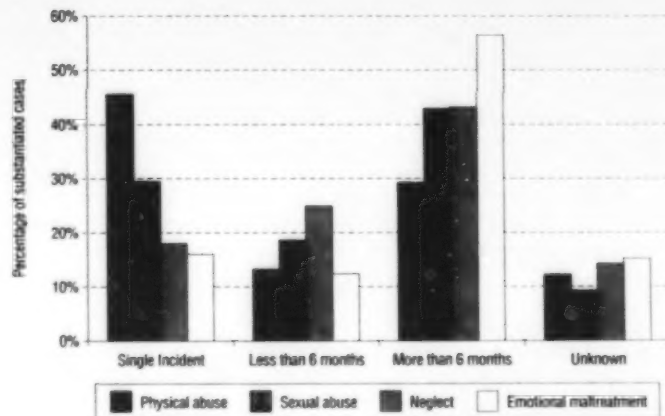
This section describes the characteristics of the major categories of substantiated maltreatment documented by the CIS. The characteristics of maltreatment include evidence of associated physical and emotional harm, the duration of the maltreatment, and children's relationships to the perpetrators, all of which have been shown to be related to increased child distress.¹⁹ The findings are presented in terms of the four major categories of **primary** maltreatment tracked by the CIS (physical abuse, sexual abuse, neglect, and emotional maltreatment) **for substantiated cases only**.

Duration

Duration of maltreatment was documented on a three-point scale as follows:

- Single incident
- Multiple incidents occurring for less than 6 months
- Multiple incidents occurring for more than 6 months

Figure 2-7
Duration of Substantiated Child Maltreatment by Primary Category of Maltreatment



Source: CIS Final Report, Table 4-3

Well over one-third (43%) of all substantiated cases of child maltreatment continued beyond 6 months in duration. Single incidents and those continuing for less than 6 months in duration accounted for another 44% of the cases. In the remaining cases, investigating workers were not able to determine the duration.

Figure 2-7 shows that emotional maltreatment was most likely to have continued beyond 6 months (56% of substantiated emotional maltreatment was over 6 months in duration), followed by sexual abuse (43%), neglect (43%), and physical abuse (29%). The figure also reveals that physical abuse and sexual abuse were somewhat more likely to involve

single incidents (46% and 29% respectively) than the other two categories of maltreatment. This latter finding is understandable, given that both of these categories of maltreatment involve more readily identified acts or behaviours that are reported, whereas neglect and emotional maltreatment are more likely to be considered chronic conditions with less specific incidents.

Physical and Emotional Harm

The CIS tracked physical harm suspected or known to be caused by the investigated maltreatment. This included suspicious injuries that were subsequently found not to be due to maltreatment, as well as injuries caused by maltreatment.

¹⁹ Beitchman JH, Zucker KJ, Hood JE, et al. A review of the long-term effects of child sexual abuse. *Child Abuse and Neglect* 1992;16:101-18.

The nature of the physical harm was documented by investigating workers according to six types of injury or health condition:

Bruises/Cuts/Scrapes: The child suffered various physical hurts visible for at least 48 hours.

Burns and Scalds: The child suffered burns and scalds visible for at least 48 hours.

Broken Bones: The child suffered fractured bones.

Head Trauma: The child was a victim of head trauma and required medical attention (e.g. child pushed down a flight of stairs, causing broken teeth).

Other Health Conditions: The child suffered from other physical health conditions, such as complications from untreated asthma or a sexually transmitted disease.

Death: The child died, and during the investigation maltreatment was suspected as the cause of death.

Across all categories of maltreatment, physical harm was documented in 17% of substantiated cases. About three-quarters of the cases involving physical harm did not require treatment, whereas in the remaining one-quarter (4% of the total number of substantiated cases) the harm was sufficiently severe to require medical treatment. Most of this

harm (65%) involved bruises, cuts, and scrapes, although there were other significant injuries and health conditions resulting from maltreatment as well.

During the 3-month CIS data collection period there was one investigation of a child abuse and neglect fatality at a participating site. This is an insufficient number to allow for the calculation of a national estimate. An average of about 100 child homicides are documented by the police every year across Canada according to the Homicide Survey, which provides information on police-reported characteristics of homicides.²⁰

Not surprisingly, physical abuse was the most common primary category of maltreatment that resulted in physical harm: almost half (44%) of all substantiated physical abuse cases documented physical harm, and some form of medical treatment was required in 6% of these cases. The vast majority of injuries (86%) involved bruises, cuts, and scrapes, and the remaining injuries were evenly distributed over the other types.

Physical harm was also documented in all other primary categories of maltreatment, although to a significantly lesser

extent (sexual abuse 8%, neglect 9%, emotional maltreatment 1%). The nature of the physical harm related to sexual abuse and emotional maltreatment was similar, and was fairly evenly split between bruises/cuts/scrapes and other health conditions. In cases of substantiated child neglect, physical harm was generally manifested by other health conditions (67% of the injuries), burns and scalds (12%), or bruises, cuts, and scrapes (16%).

To assess emotional harm, child welfare workers were asked to describe the mental/emotional harm or trauma that was suspected or known to have been caused by the maltreatment. They were asked to include changes in the child's development (regression, withdrawal), self-regulation (sleep patterns, elimination), and emotions (child crying, clinging, or anxious) that were apparent for at least 48 hours.

Unlike physical injuries, which can usually be linked to specific incidents of maltreatment, it is more difficult to link emotional harm to specific incidents. To account for this difficulty, investigating workers were asked to rate general child functioning in addition to documenting maltreatment-specific mental/emotional harm.

²⁰ Fitzgerald R. *Assaults against children and youth in the family, 1996*. Canadian Justice Statistics. Ottawa: Statistics Canada, 1996.

The child functioning ratings are presented later in this report.

Emotional harm was noted in one-third (34%) of all substantiated maltreatment investigations. Problems identified as emotional harm were severe enough to warrant treatment in 21% of the cases, and treatment was not deemed necessary in the remaining 13%.

Understandably, emotional harm was noted most often in sexual abuse cases, since these children have been assaulted and traumatized in ways that seldom produce physical injuries. Nearly half (47%) of the substantiated cases of sexual abuse were described as involving emotional harm. Moreover, harm was severe enough in 38% of the sample of sexually abused children to require treatment; in 9%, symptoms were noted, but treatment was not considered to be necessary.

Emotional harm was associated with the other three primary categories of maltreatment as well. Again, this finding is not surprising given the nature of child maltreatment and the ways that child victims attempt to cope with or react to such events. About one-third of substantiated cases of physical abuse, neglect and emotional maltreatment involved emotional harm, with treatment required in over half of the cases.

Alleged Perpetrators

In substantiated cases, the alleged perpetrator was the person or persons who were determined by the child welfare investigator to have maltreated the child.²¹ Seven pre-coded classifications of alleged perpetrators were tracked:

Mother: Biological parent

Father: Biological parent

Step-father: Included common-law partner

Step-mother: Included common-law partner

Sibling: Sibling or half-sibling of the child

Stranger: Unknown person to the child and family

Other: Any other individual

Alleged perpetrators classified under the "other" category were recoded under 22 additional categories, including adoptive or foster parents, grandparents, extended family, family acquaintances, and involved professionals. On the basis of the frequency of response, these were combined into the following nine classifications:

Adoptive Parents/Foster Family: Includes adoptive parents and foster family.

Other Relative: Any other relative, adult or child, who had contact with the investigated child (e.g. grandparent, aunt/uncle, sibling).

Family Friend: Friend of the caregiver(s) living with the child.

Parent's Boyfriend/Girlfriend: Parent's partner not in a caregiving role.

Child's Friend (peer): Another child considered a friend or peer.

Babysitter: An individual of any age in a babysitting role to the child.

Teacher: Includes teachers but not other school personnel (e.g. caretakers).

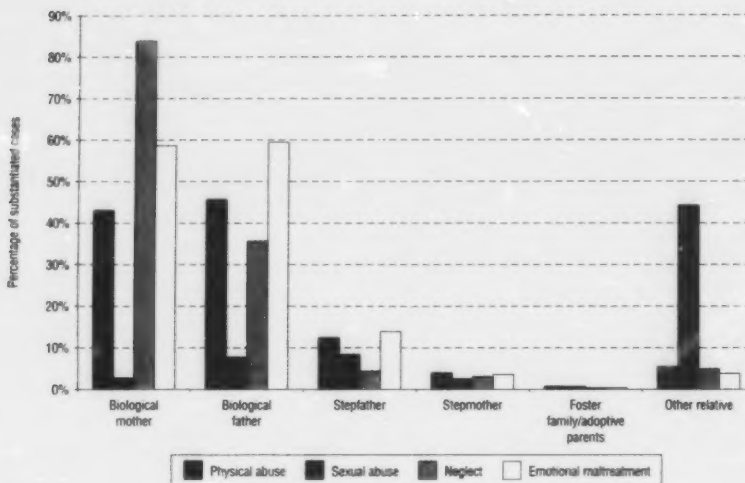
Other Professional: Includes recreation, health, and social service professionals.

Other Acquaintance: An individual known to the child's family.

Across all four categories of substantiated maltreatment, family members or other persons related to the child victim constituted the vast majority (93%) of alleged perpetrators. Not surprisingly, one or both biological parents were most often the alleged perpetrator (with the notable exception of sexual abuse, discussed later). Across all categories of maltreatment, biological mothers were identified as the alleged perpetrator most often (60% of substantiated cases), followed by biological fathers (41%), step-fathers/common-law partners (9%) and step-mothers/common-law partners (3%). Other than these parents or parent figures,

²¹ This determination is not equivalent to a finding of guilt in a criminal court.

Figure 2-8
Alleged Perpetrator in Substantiated Child Maltreatment, Relatives,
by Primary Category of Maltreatment



Source: CIS Final Report, Table 4-4(a)

other relatives were the most frequently identified alleged perpetrators (9%). Foster families and adoptive parents had a negligible number of reports. It should be noted that the CIS only counted new child maltreatment investigations; investigations conducted on open cases were not captured.

Alleged perpetrators who were non-relatives (7% of substantiated cases) included babysitters, family friends, parental partners, teachers, other professionals, acquaintances, and strangers. Over half of these non-related alleged perpetrators (4% of the total) were close to the child and family, such as friends,

parent's boy/girlfriend, and babysitters. It should be noted, however, that in many instances non-familial allegations of abuse are investigated by the police, not by a child welfare authority.²²

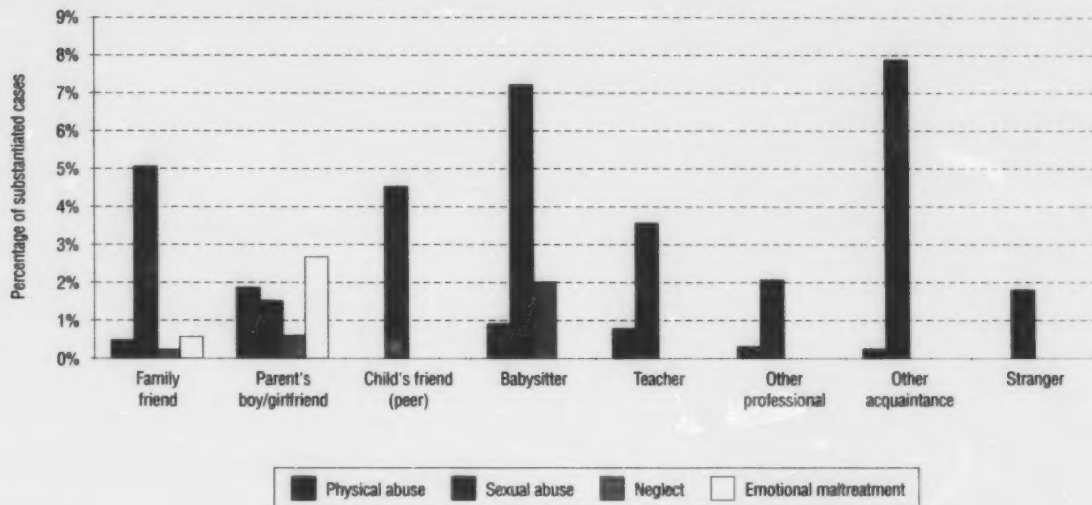
Figure 2-8 shows alleged perpetrators who were related to the child, broken down by the four primary categories of maltreatment. Similarly, Figure 2-9 shows alleged perpetrators who were unrelated to the child. The reader should note that some substantiated cases had more than one alleged perpetrator, so these percentages exceed 100%.

Physical abuse was committed largely by biological mothers and fathers (see Figure 2-8). In particular, fathers were the alleged perpetrator in almost half (46%) of substantiated cases of physical abuse, closely followed by mothers (43%). This distribution may be somewhat biased by the fact that 40% of investigated families were female-parent families (discussed in chapter 7 of the *CIS Final Report*). Among non-relatives (Figure 2-9), perpetrators of substantiated physical abuse were primarily parent's girlfriend/boyfriend (2%) or babysitters (1%). Although there were substantiated cases of physical abuse involving other non-relatives (such as other acquaintances and teachers), these numbers were very small and less reliable.

Sexual abuse, in contrast to the other categories of maltreatment, was committed much less often by the child's primary caregiver. Most alleged perpetrators were either other relatives (44% of cases) or non-relatives (29%). Figure 2-8 shows that alleged perpetrators who were related to the child victim were equally likely to be a biological father or stepfather and less likely to be the child's biological mother or a foster or adoptive parent. Although a specific breakdown on the particular relationship to the child

²² Trocmé N, Brison R. Homicide and injuries due to assault and to abuse and neglect. In: Beaulne G (ed). *For the safety of Canadian children and youth: from data to preventive measures*. Ottawa: Health Canada, 1998.

Figure 2-9
Alleged Perpetrator in Substantiated Child Maltreatment, Non-Relatives, by Primary Category of Maltreatment



Source: CIS Final Report, Table 4-4(b)

of "other relatives" is not shown, it is clear from Figure 2-8 that this grouping is the single most significant category of individuals who commit such acts (44%).

Non-relative alleged perpetrators of sexual abuse were connected to the child's life in the vast majority of cases. As shown in Figure 2-9, they were family friends (5%), parent's boyfriend or girlfriend (2%), babysitters (7%), teachers (4%), other professionals (2%), other acquaintances (8%) and, in some instances, a child's friend or peer (5%). Notably, very few substantiated sexual abuse cases involved a stranger (2%).

Child neglect, like physical abuse, was largely committed by

biological mothers (84%) and biological fathers (36%). Biological mothers may be over-represented in the neglect category because 40% of investigations involved female-parent families. The findings may reflect the inter-connection between child neglect, poverty, and single female-headed households. Although child neglect rarely involved non-relatives, babysitters and parent's girlfriend/boyfriend taken together were involved in about 3% of the cases (Figure 2-9).

Emotional maltreatment, like physical abuse and neglect, was largely committed by biological mothers (59%) and fathers (59%). Step-fathers were the alleged perpetrators in 14% of cases. In

the few instances involving non-relatives (3% of the total), the parent's boyfriend or girlfriend was implicated.

Summary

An estimated 135,573 child maltreatment investigations were conducted in Canada in 1998, which corresponds to an estimated incidence rate of 21.52 investigations per 1,000 children. This incidence rate includes *all* child maltreatment investigations, regardless of whether the investigation was substantiated or not.

Almost half (45%) of the investigations were substantiated by the investigating worker. Of the estimated 21.52 investigations per

1,000 children in Canada in 1998, an estimated 9.71 per 1,000 were substantiated, 4.71 per 1,000 were suspected, and 7.09 per 1,000 were unsubstantiated.

The most common primary reason for child maltreatment investigation in Canada was child neglect, which accounted for about 2 out of every 5 investigations of child maltreatment. Child physical abuse was the second most common (31%), followed by emotional maltreatment (19%), and sexual abuse (10%). Emotional maltreatment, however, had the highest substantiation rate, at over half of these investigations. The other categories of maltreatment had similar levels of substantiation: about 1 in 3 cases of physical abuse and sexual abuse were substantiated, and about 2 in 5 cases of neglect.

Most cases of substantiated child physical abuse involved inappropriate punishment, and about one-third involved more

severe forms of abuse. Touching and fondling of the genitals was the most common form of abuse in substantiated child sexual abuse. Neglect involved a number of different parental acts, the most common concern being failure to supervise the child properly leading to physical harm. Children's exposure to family violence was the most common form of emotional maltreatment, accounting for well over half of the substantiated cases.

Child maltreatment was a chronic event in over a third of the substantiated cases, continuing beyond 6 months in duration. Emotional maltreatment was the most likely type to continue beyond 6 months, followed by neglect, sexual abuse, and physical abuse.

Physical harm to the child was documented in 16% of all substantiated cases. Physical abuse was the most common category of mal-

treatment that resulted in physical harm. In addition to physical harm, emotional harm was noted in one-third of all substantiated investigations. Emotional harm was noted most often among sexually abused children, and many of these children required treatment for such harm.

There was a clear distinction between the alleged perpetrators of child sexual abuse and those of the other three categories of substantiated maltreatment. Biological parents, in particular, were less likely to be the alleged perpetrator of this category of maltreatment, whereas they were the predominant offender in the other three categories. Other relatives and non-relatives constituted the vast majority of alleged perpetrators of child sexual abuse, almost all of whom had a known connection to the child victim by virtue of their family ties or responsibilities (e.g. teachers, babysitters, family friends).

■ 3. CHILD AND FAMILY CHARACTERISTICS

This chapter provides a description of children and their families in substantiated investigations of child maltreatment. Basic information on children's age, sex, and functioning add an important part of the picture in describing and understanding the four primary categories of maltreatment (physical abuse, sexual abuse, neglect, and emotional maltreatment).²³ For example, children's developmental status or disabilities (such as developmental delay or attention deficit/hyperactivity disorder) may pose a greater challenge to caregivers, especially those who lack support. Although children are never responsible for their own maltreatment, an understanding of those characteristics related to child maltreatment helps to inform practitioners and researchers of the risk to children based on their age, sex, or special needs.

Child maltreatment is also closely linked to structural aspects of the family, neighbourhood, and community. As a result, some of the most prominent social and cultural dimensions contributing to maltreatment stem from poverty, social isolation, and inequality. Important aspects of the neighbourhood context reflect the degree of breakdown of community social

control and organization, which in turn relate to reports of child maltreatment. Accordingly, this chapter also provides an overview of the characteristics of the households of investigated children tracked by the CIS, which include household composition (parents, step-parents, siblings), housing, source of income, parental functioning, and family stressors.

It should be noted that the information in this chapter does not include comparisons between the characteristics of children and families in cases of substantiated child maltreatment and these characteristics in the general Canadian population. An exception is the section on household structure, which includes some relevant data from the census. Further analysis will be required in order to understand more fully the contribution of the various child and family characteristics to the risk of maltreatment.

Child Characteristics

Age and Sex of Maltreated Children

Knowledge of the age and sex of maltreated children adds to an understanding of the possible

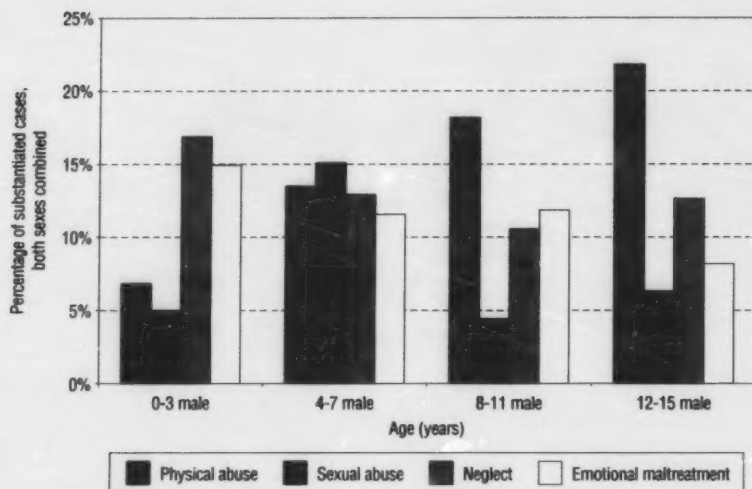
developmental factors that might increase the risk of maltreatment. Certain types of child maltreatment may be more likely to occur at particular ages, or to one sex more than the other. For example, child neglect might be expected to be more common among younger children (infancy and toddlerhood), who require greater parental supervision.

Across categories of maltreatment, 51% of substantiated cases involved boys and 49% involved girls. Age and sex patterns associated with each primary category of substantiated maltreatment are shown in Figure 3-1(a) for males and 3-1(b) for females, and are discussed below.

Physical Abuse: Sixty percent of substantiated cases of physical abuse involved boys, and 40% involved girls, although the age patterns were the same for both sexes. As shown in Figures 3-1(a) and 3-1(b), the highest proportions of substantiated physical abuse were in the adolescent age group (boys 22% and girls 18%). Notably, there was a linear age trend for both sexes, in that physical abuse was generally lower in the youngest age group (0-3 years) and increased incrementally among older children.

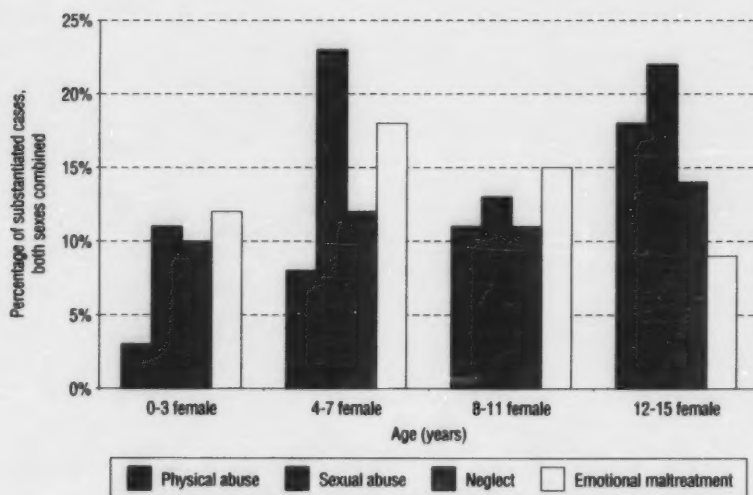
²³ Cases involving more than one category of maltreatment were classified under the primary category specified by the investigating worker.

Figure 3-1(a)
Ages of Children: MALES by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table 6-3

Figure 3-1(b)
Ages of Children: FEMALES by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table 6-3

Sexual Abuse: In substantiated cases of sexual abuse, 69% of the victims were girls and 31% were boys. In contrast to physical abuse, notable age differences were evident for the sexes. Figure 3-1(a) shows that 4-7 year old boys accounted for about three times more cases than other age groups of boys. Figure 3-1(b) reveals that girls aged 4-7 and 12-15 were the victim in about twice as many cases of sexual abuse as either of the other two age groups.

Neglect: Among substantiated cases of neglect, the age and sex distribution was generally even, with boys accounting for slightly over half (53%) of the cases. The highest proportions of these cases occurred among boys aged 0-3 years (17%) and girls aged 12-15 (14%); there was little variability in the proportions for either sex across the other age groups.

Emotional Maltreatment: Similar to neglect, there was an even distribution of age and sex in substantiated cases of emotional maltreatment. Girls accounted for slightly more cases (53%) than boys (47%). The older age groups of boys and girls accounted for the lowest proportions of cases, and girls aged 4-7 were the victim in the highest proportion of cases (18%).

Child Functioning

Maltreated children experience ongoing, uncontrollable events that are a pervasive challenge to their successful development and adaptation and pose a threat to their core psychological well-being. They not only have to face acute and unpredictable parental outbursts or betrayal, they also have to adapt to environmental circumstances that pose developmental challenges. These influences include the more dramatic events, such as marital violence and separation of family members, as well as the mundane but important everyday activities that may be disturbing or upsetting, such as unfriendly interactions, few learning opportunities, and chaotic lifestyle.

Although many abused children who face these developmental challenges will not develop a psychological disorder, they are at a much greater risk of significant emotional and adjustment problems, including aggression and violence.²⁴ For example, children who are sexually abused undergo pronounced interruptions in their developing view of themselves and the world, which can result in significant emotional and behavioural changes indicative of their attempts to cope

with such events. Because the source of stress and fear may be within their family, children who are maltreated are challenged on a regular basis to find ways to adapt that pose the least risk and offer maximum protection and opportunity for growth.

Child functioning was documented on the basis of a short checklist of problems that child welfare workers were likely to be aware of as a result of their investigation. The child functioning checklist was developed in consultation with child welfare workers and researchers to reflect the types of concerns that may be identified during an investigation. The checklist is not a validated measurement instrument for which population norms have been established.²⁵ Although the checklist documents only the problems that child welfare workers became aware of during their investigation, and therefore undercounts the incidence of child functioning problems,²⁶ it nevertheless provides a first estimate of the types of concerns that are identified during child maltreatment investigations. At this point, we are not positing a cause-and-effect relationship between these factors and the child maltreatment.

Investigating workers were asked to indicate problems that had been confirmed by a formal diagnosis and/or directly observed, as well as issues that they suspected were problems but could not fully verify at the time of the investigation. The 6-month period before the investigation was used as a reference point where applicable. Child functioning classifications that reflect physical, emotional, and cognitive health and behavioural issues were documented with a checklist that included the following categories:

Developmental Delay:

Child has a diagnosis of a developmental delay, or developmental delay was clearly indicated by the child's appearance or behaviour.

Physical/Developmental

Disability: Child has a diagnosis or indication of physical/developmental disabilities (e.g., autism, paralysis, cerebral palsy or learning disability).

Substance Abuse Related

Birth Defects: Child has a diagnosis or indication of birth defects related to substance abuse of the biological mother (e.g. fetal alcohol syndrome/fetal alcohol effect).

Other Health Condition:

Child has ongoing physical health condition (e.g. chronic

²⁴ Malinosky-Rummell R, Hansen DJ. Long-term consequences of childhood physical abuse. *Psychological Bulletin* 1993;114:68-79.

²⁵ A number of child functioning measures with established norms exist; however, these are not currently used in child welfare settings and could not be feasibly used in the context of the CIS.

²⁶ Items on the checklist only include issues that child welfare workers happen to become aware of during their investigation. A more systematic assessment would therefore likely lead to the identification of more issues than noted by workers during the CIS.

disease and frequent hospitalization).

Specialized Education Class: Child has been involved in special education program for learning disability, special needs, or behaviour problems.

Depression or Anxiety: Child has a diagnosis or indication of being extremely anxious or depressed.

Self-Harming Behaviour: Child has engaged in high-risk or life-threatening behaviour, suicide attempts, and physical mutilation or cutting.

Psychiatric Disorder: Child has diagnosis of psychiatric disorder by a psychiatrist (e.g. conduct disorder, anxiety disorder).

Behaviour Problems in the Home/Community: Child has displayed significant behavioural problems in the home or the community (e.g. school refusal, aggression, violence, and gang involvement).

Negative Peer Involvement: Child has been involved in high-risk peer activities, such as gang activities or vandalism.

Substance Abuse: Child has abused any type of substance, including prescription drugs, alcohol, illegal drugs, and solvents.

Violence to Others: Child has displayed aggression and violence toward other children, adults, or property in the home, school, or community.

Running: Child has run away from home (or other residence) on at least one occasion, for at least one overnight period.

Irregular School Attendance: Child has irregular attendance and truancy (over 5 days/month).

Involvement in Prostitution: Child has been involved in prostitution or sex trades in any way.

Age-Inappropriate Sexual Behaviour: Child has been involved in age-inappropriate sexual behaviour with friends or with family members.

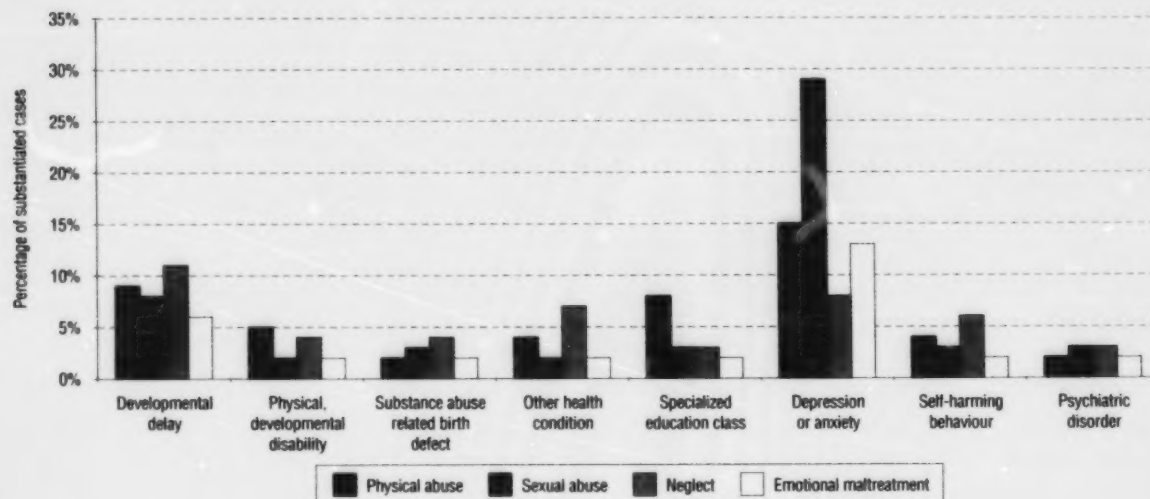
Criminal/YOA Involvement: Child has been involved in charges, incarceration, or alternative measures under the Young Offenders Act.

Concerns about the needs of the child victim are reflected in the finding that at least one child functioning issue was indicated by the investigating worker in half (50%) of all substantiated cases of child maltreatment. At least one physical, emotional, or cognitive child functioning issue was reported in almost one-third (30%) of the cases. The most common concerns related to child depression or anxiety and developmental delays (13% and 9% of substantiated cases respectively).

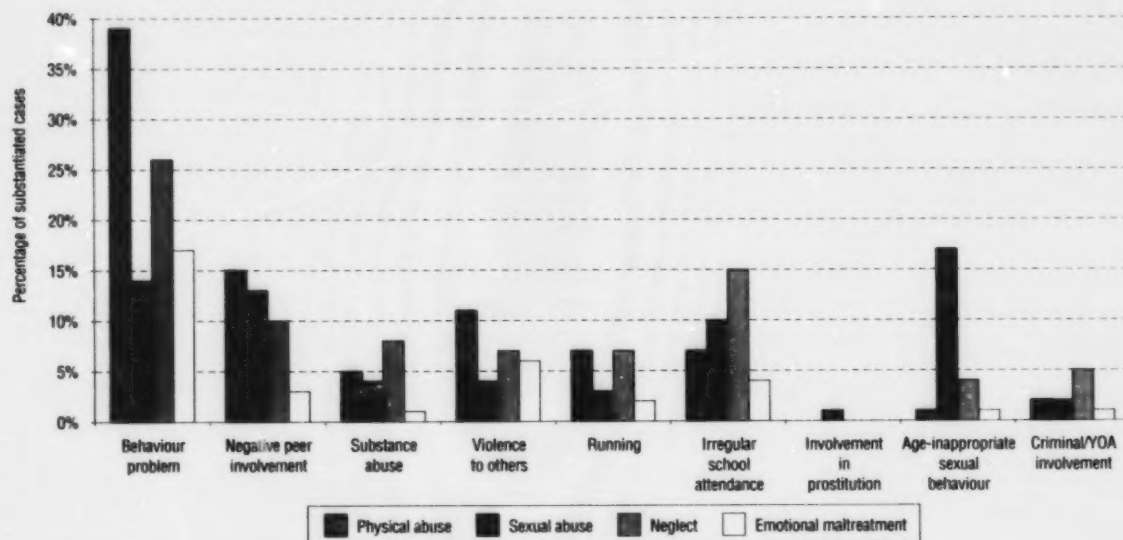
Similarly, at least one behavioural functioning issue was reported in over one-third (38%) of substantiated cases. Behaviour

problems were the most frequently described child problems, reported in about 1 in every 4 (26%) children. Negative peer involvement, irregular school attendance, and violence to others were also of considerable concern, each issue being reported in almost 10% of the cases. There were not enough cases documenting prostitution to provide a reliable estimate of the number of investigations in which prostitution was noted as a child functioning issue. It is important to note that these ratings are based on the initial intake investigation, and do not capture behaviours that may become concerns after the initial investigation.

Physical Abuse: Physically abused children were generally reported as having considerable problems in child functioning across several types. Notably, in over half (56%) of substantiated physical abuse cases, the child was described as having some type of child functioning issue. As shown in Figures 3-2(a) and 3-2(b), the five most often indicated concerns were behaviour problems (39%), negative peer involvement (15%), depression or anxiety (15%), violence to others (11%), and developmental delay (9%). Overall, a physical, emotional, or cognitive health issue was reported in 31% of substantiated physical abuse cases, and a behavioural issue was indicated in almost half (49%).

Figure 3-2 (a)**Child Functioning: Physical, Emotional, and Cognitive Health by Primary Category of Substantiated Maltreatment**

Source: CIS Final Report, Table 6-4(a)

Figure 3-2 (b)**Child Functioning: Behavioural, by Primary Category of Substantiated Maltreatment**

Source: CIS Final Report, Table 6-4(b)

Sexual Abuse: Sexually abused children were also reported as having a wide range of difficulties, as reflected in the finding that 58% of all substantiated cases had some child functioning issue. Figures 3-2(a) and 3-2(b) show that the five most often reported child functioning issues were depression or anxiety (29%), age-inappropriate sexual behaviour (17%), behaviour problem (14%), negative peer involvement (13%), and irregular school attendance (10%). Somewhat surprisingly, running away from home was noted in only 3% of sexual abuse cases compared with 7% of physical abuse and neglect cases. Overall, a physical, emotional, or cognitive health issue was reported in 42% of substantiated sexual abuse cases, and a behavioural issue was indicated in about one-third (34%).

Neglect: In just over half (52%) of the substantiated cases of neglect, the child was described as showing some form of child functioning issue. Figures 3-2(a) and 3-2(b) show that the pattern of concerns related to child functioning of neglected children was similar to that of physical abuse, although to a somewhat lesser

degree: the four most common indicated concerns were general behaviour problems (26%), irregular school attendance (15%), developmental delay (11%), and negative peer involvement (10%), with depression/anxiety reported among 8% of the cases of neglect. Overall, a physical, emotional, or cognitive health issue was reported in 30% of substantiated neglect cases, and a behavioural issue was indicated in over one-third (39%).

Emotional Maltreatment: Child functioning issues were least often noted in cases of emotional maltreatment: in just over one-third (36%) of substantiated cases, the child was described as having one or more concerns. Figures 3-2(a) and 3-2(b) show that the two most often reported issues were depression or anxiety (13%) and behaviour problems (17%). Overall, a physical, emotional, or cognitive health issue was reported in 22% of emotional maltreatment cases, and a behavioural issue was indicated in 1 in 4 (25%).

Family Characteristics

Parents and Other Family Members in the Home

Family characteristics provide important information concerning the household structure and context of child maltreatment. Research suggests, for example, that children living with a single parent are at significantly greater risk of both physical abuse and neglect, most likely because of added stress, fewer resources and opportunities to share child-rearing burdens, and lower socioeconomic status than in two-parent homes.²⁷ Similarly, maltreatment, especially physical and educational neglect, is more common in larger families, where additional children in the household mean additional tasks, responsibilities, and demands.

The CIS gathered information on up to two of the child's parents or other caregivers.²⁸ For each listed caregiver, investigating workers were asked to choose the category that best described the relationship between the caregiver and the children in the home. If a caregiver was a biological parent to one child and a step-parent to

²⁷ National Research Council. *Understanding child abuse and neglect*. Washington: National Academy Press, 1993.

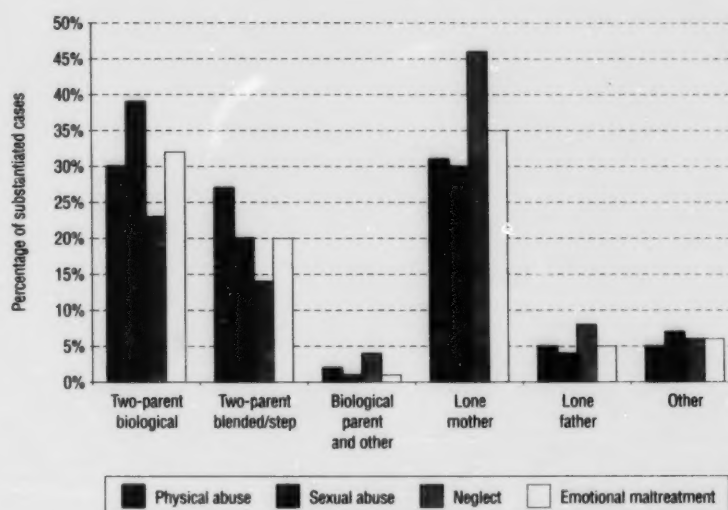
²⁸ The two-caregiver limit was required to accommodate the form length restrictions set for the Household Information Sheet. The caregiver information usually corresponded to the parents and/or step-parent living in the home; if there was only one caregiver living in the home and a second living outside the home, information was gathered on both of these, but information on the latter is not reported here.

another child in the family, workers were asked to use "step-parent" to describe that caregiver.²⁹ If recent household changes had occurred, investigating workers were asked to describe the situation at the time the referral was made.

Across all categories of substantiated maltreatment, almost half (44%) of the cases involved children who lived in a family led by a lone parent: over one-third (38%) of the children lived alone with their mother, and 6% with their father. Another 28% of cases involved children who lived with their two biological parents, and in 19% the child lived in a two-parent blended family in which one of the caregivers was a step-parent, a common-law partner, or an adoptive parent who was not the biological parent of at least one of the children in the family. In comparison, census data show that families led by female parents represented 17% of families with children under the age of 17 in 1996; 80% of the families were husband-wife led.³⁰

Figure 3-3 shows the household structure according to primary category of substantiated maltreatment. In general, household

Figure 3-3
Household Structure by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table 7-1

structure did not vary significantly by category of maltreatment: most children were living either with two biological or step-parents, or with their mother. However, as shown, sexually abused children were most likely to be living with their two biological parents, and neglected children most likely to be living with a single mother.

About one-half (51%) of substantiated maltreatment involved children with at least one additional sibling who was also the subject of investigation. Siblings

were more likely to be investigated in cases involving neglect (53%) and emotional maltreatment (67%) than physical (36%) or sexual abuse (42%).

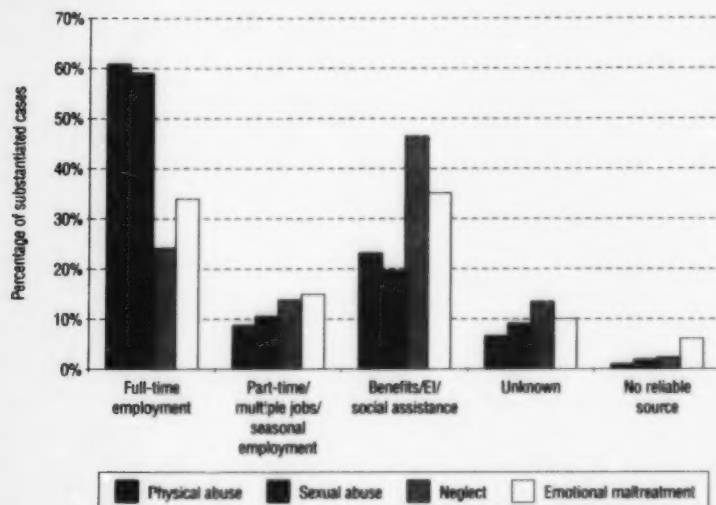
Family Income

Child maltreatment is affected by several major environmental conditions, of which low socio-economic status (typically defined as family income below the poverty line, under-employment, and low education) and housing conditions play a significant role.

²⁹ This compromise was needed because the Household Information Sheet served as a common information source for all the children in the family. A much more extensive set of questions would have been required had the CIS gathered child-specific caregiver information, leading to a significantly longer form. Child-specific information on the caregiver-child relationship is available for caregivers who were investigated as alleged perpetrators.

³⁰ Statistics Canada. *Census families in private households by age groups of never-married sons and/or daughters at home, showing family structure*. Catalogue No. 93F0022XDB96009. Ottawa: Statistics Canada, 1996.

Figure 3-4
Household Source of Income by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table 7-5

Recent studies suggest that the connection between child maltreatment and poverty is not likely due to a reporting bias.³¹ This implies that the economically based context of maltreatment — restricted childcare opportunities, crowded and unsafe housing, and so forth — is a powerful contributor to incidence rates.

Investigating workers were requested to choose the income source that best described the primary source of the caregiver's income. Income source was designated by investigating workers in terms of six possible classifications:

Full Time: At least one caregiver was employed in a permanent, full-time position.

Part Time/Multiple Jobs/Seasonal Employment: Family income was derived primarily from part-time employment (less than 30 hours/week), several part-time temporary jobs, or full-time or part-time positions for temporary periods of the year. Neither caregiver was employed in a permanent, full-time position.

Benefits/Employment Insurance (EI)/Social Assistance: Family income was derived primarily from benefits (e.g. long-term disability, pension, or child support), employment insurance benefits, or social assistance

(e.g. general welfare or family assistance).

Unknown: Source of income was not known.

No Reliable Source: There was no reliable source of income for the family. Caregiver(s) may have worked at temporary jobs, but these were not predictable and could not be relied on for financial budgeting.

Information not provided: Source of income was not provided.

Over half (51%) of the families in substantiated cases of child maltreatment derived their primary income from full- or part-time employment, and over one-third (35%) relied on social assistance or some other form of benefits.

Figure 3-4 shows the sources of household income for each primary category of substantiated maltreatment. A clear distinction in source of income is evident between physical and sexual abuse, and neglect and emotional maltreatment. About 60% of families of physically or sexually abused children derived their household income from full-time employment, compared with 24% of families involved in neglect and 34% of families involved in emotional maltreatment. Neglect and emotional maltreatment were more likely to be associated with families

³¹ Pelton LH. The role of material factors in child abuse and neglect. In: Melton GB, Barry FD (eds). *Protecting children from abuse and neglect: foundations for a new national strategy*. New York: Guilford, 1994:131-81.

who relied on social assistance or some other form of benefit.

Housing

Child maltreatment, neglect in particular, is often associated with a lack of basic necessities that keep children safe and healthy. Poverty, family chaos and unpredictability, household crowding, and frequent residence changes have been shown to be characteristic of both unintentional child injury as well as child maltreatment, suggesting that risk of injury is amplified as the number of such stressors increases.³² In addition, home safety includes many factors, such as children's exposure to toxic substances, improper storage of medications or firearms, disrepair of and unsafe heating appliances. Similarly, the household can pose a hazard to children's health and safety if parents/caregivers do not properly look after pets, laundry, dishes and similar day-to-day chores.

Investigating workers were asked to select the housing accommodation category that best described the investigated child's household situation:

Private Rental Accommodation: A private rental unit, including an apartment unit, a house, or a townhouse.

Rental Unit in a Public Housing Complex: A rental unit in a public housing complex (i.e. rent-subsidized, government-owned housing).

Purchased Home: A purchased house, condominium, or townhouse.

Shelter/Hotel: A homeless or family shelter, SRO hotel (single room occupancy), or temporary motel accommodation.

Unknown: Housing accommodation was unknown.

Other: Any other form of shelter (Armed Forces barracks or housing, trailers, mobile homes, etc.).

In addition to housing type, investigating workers were asked to indicate whether the investigated child lived in unsafe housing conditions where children were at risk of injury or impairment from their living situation (e.g. broken windows, insufficient heat, parents and children sharing single room). Workers also noted the number of family moves in the 6 months before the investigation.

At the time of the study, over half of all substantiated cases of maltreatment involved children living in rental accommodations (44% private market rentals and 12% public housing), 28% in purchased homes, and 1% in shelters or hostels. Housing

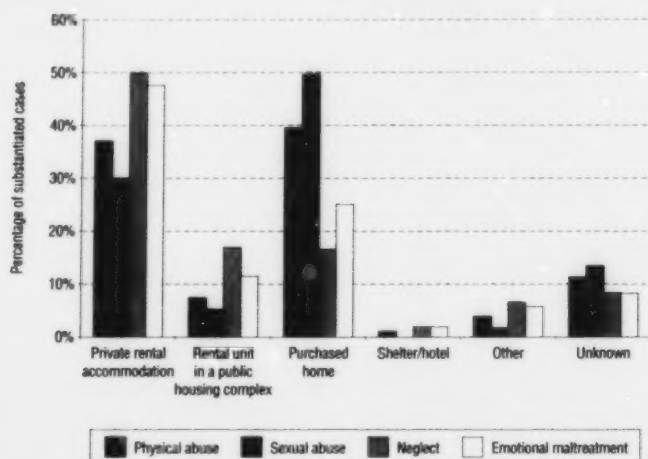
conditions were mostly described as safe (63%), although in more than 1 in 5 cases (22%) the child was considered to be living in unsafe conditions. In addition, in about 1 in 4 cases of maltreatment the child had experienced one or more moves in the previous 6 months.

Physical Abuse: Most cases of substantiated physical abuse involved children living in private rental accommodations (37%) or in a purchased home (40%) (Figure 3-5). Unsafe housing conditions were noted in 14% of these cases. Additionally, in most cases (55%) the child had not moved in the previous 6 months, although in another 18% the child had experienced one or more moves.

Sexual Abuse: Like physical abuse, most substantiated sexual abuse cases involved children who were living in purchased homes (50%) or private rental accommodations (30%). Conditions in the home were considered unsafe in 18% of the cases, slightly more than in physical abuse. Children in substantiated sexual abuse investigations had the lowest rate of moves, 63% not having moved in the previous 6 months, and 13% having experienced one or more moves.

³² Peterson L, Brown D. Integrating child injury and abuse-neglect research: common histories, etiologies, and solutions. *Psychological Bulletin* 1994;116:293-315.

Figure 3-5
Housing Type by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table 7-6

Neglect: In contrast to physical and sexual abuse, only 17% of substantiated neglect investigations involved children living in purchased homes. The majority (67%) lived in private market rentals or public housing complexes. As well, child neglect was associated with the highest rate of unsafe housing conditions (31%) and the greatest number of moves; that is, in almost 1 in 3 cases (29%) the child had moved at least once in the previous 6 months.

Emotional Maltreatment: Like child neglect, the majority of substantiated emotional maltreat-

ment investigations involved children living in private and public rental accommodations (59% over both categories), with 25% living in purchased homes. The rate of unsafe housing conditions (16%) was comparable with that in physical and sexual abuse. One in four (25%) of the cases involved children who had experienced one or more moves in the previous 6 months.

Caregiver Functioning and Family Stressors

Maltreating parents often have had little exposure to positive parental models and supports, and

their family backgrounds are often difficult and marked by violence, alcoholism, and harsh family circumstances. They find daily living stressful and irritating, and thus prefer to avoid potential sources of support because additional energy is needed to maintain social relationships. Sadly, spouse abuse is more likely to co-occur with child maltreatment. It is estimated that in 30% to 60% of families in which there is either child maltreatment or woman battering, the other form of violence also occurs.³³

Maltreating families also lack significant social connections to others in the extended family, the neighbourhood, the community, and to the social agencies that are most likely to provide needed assistance.³⁴ Social isolation is commonly associated with other stressful living conditions, such as a lack of adequate day care, peer groups or close friends, and adequate housing.³⁵ Moreover, the social life of the child can be restricted as a result of the need to keep the home situation out of public view.

Investigating workers examined concerns related to family stressors and caregiver functioning with the

³³ Edleson JL. The overlap between child maltreatment and woman battering. *Violence Against Women* 1999;5:134-54.

³⁴ Korbin JE. Sociocultural factors in child maltreatment. In: Melton GB, Barry FD (eds). *Protecting children from abuse and neglect: foundations for a new national strategy*. New York: Guilford, 1994:182-223.

³⁵ Thompson RA. Social support and the prevention of child maltreatment. In: Melton GB, Barry FD (eds). *Protecting children from abuse and neglect: foundations for a new national strategy*. New York: Guilford, 1994:40-130.

use of a checklist of 10 items that could apply to either caregiver. Where applicable, the reference point for identifying concerns about caregiver functioning was the previous 6 months.³⁶ The checklist included the following:

Alcohol or Drug Abuse: Use of alcohol was suspected or known to pose a problem for the family, or at least one caregiver was suspected or known to abuse prescription drugs, illegal drugs, or other substances.

Criminal Activity: At least one caregiver was suspected or known to allow criminal acts to be committed with the children's knowledge, or was absent because of incarceration.

Cognitive Impairment: The cognitive ability of at least one caregiver was suspected or known to have an impact on the quality of care provided in the family.

Mental Health Problems: At least one caregiver was suspected or known to have mental health problems.

Physical Health Issues: At least one caregiver was suspected or known to have a chronic illness, frequent hospitalizations, or physical disability.

Lack of Social Supports: At least one caregiver was suspected or known to be

socially isolated or lacking in social supports.

Childhood History of Abuse: Either caregiver was known or suspected to have a history of childhood maltreatment.

Spousal Violence: Either caregiver was known or suspected to be in a violent relationship.

Custody Dispute: Ongoing child custody dispute before the courts was known to the investigating worker.

Other Concerns: Any other issue/concern that described caregiver functioning.

Problems relating to caregiver functioning and family stressors were relatively common across the four categories of substantiated maltreatment. At least one caregiver functioning issue/family stressor was identified in 74% of substantiated investigations. Alcohol/drug abuse and mental health problems affected 40% and 28% of caregivers respectively. Not surprisingly, families were also described as having many other major stressors and background factors that may play a role in maltreatment, such as a childhood history of abuse (38%), spousal violence (33%), and custody disputes (9%). Moreover, about 1 in 3 families were described as lacking supports. Note that workers may

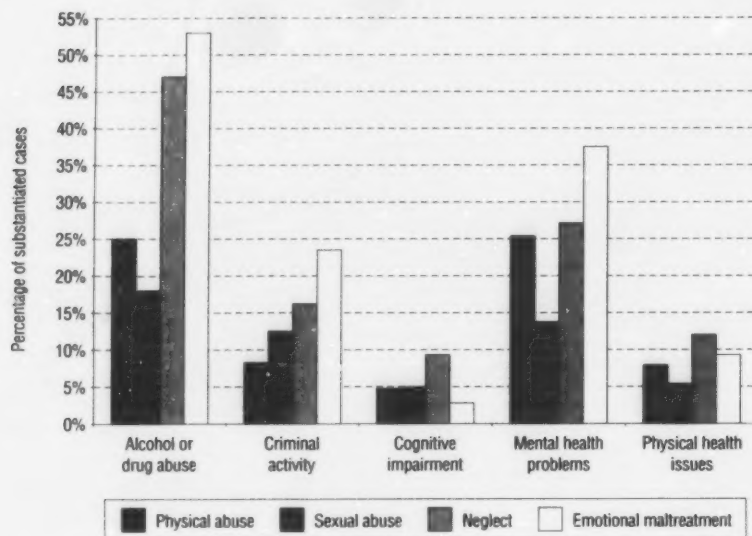
indicate more than one issue for each caregiver or family, so the percentages exceed 100%. Figures 3-6(a) and 3-6(b) present caregiver functioning and family stressors for each primary category of substantiated maltreatment.

Physical Abuse. At least one caregiver functioning/family stressor issue was identified in two-thirds (66%) of substantiated physical abuse cases. The most common concerns involved a history of child abuse (35%) and lack of social supports (28%). Mental health and substance abuse problems were each present in 25% of cases. In addition, caregivers and families of physically abused children struggled with custody disputes and had numerous other concerns noted by the worker.

Sexual Abuse. Families and caregivers of child sexual abuse victims were described as having somewhat fewer problems or concerns than the other three categories of maltreatment, although they were not free from such concerns: at least one caregiver functioning/family stressor issue was identified in over half (55%) of the substantiated cases of sexual abuse. A childhood history of abuse was the most commonly reported concern

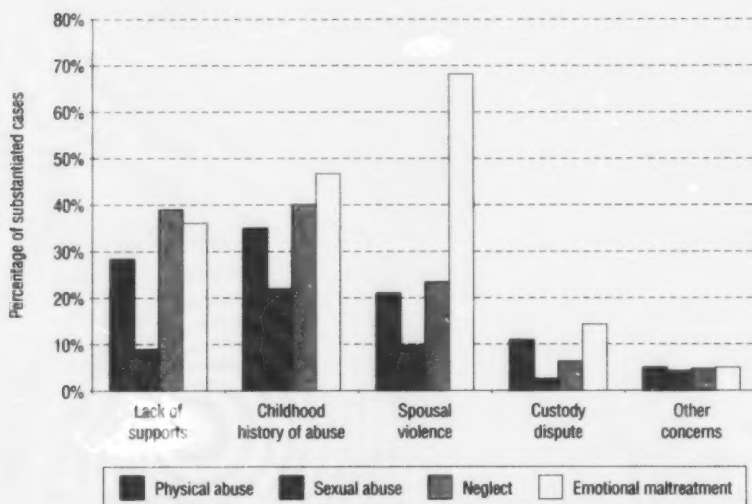
³⁶ Most items were rated on a two-point scale differentiating "confirmed" and "suspected" caregiver functioning issues. An issue was classified as confirmed if a problem had been diagnosed, observed by the investigating worker or another worker, or disclosed by the caregiver. An issue was classified as "suspected" if the investigating worker's suspicions were sufficient to include the concern in their written assessment of the family. For the purposes of the present report, the two categories have been collapsed.

Figure 3-6 (a)
Caregiver Functioning and Family Stressors by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table 7-10(a)

Figure 3-6 (b)
Caregiver Functioning and Family Stressors by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table 7-10(b)

(22%). Additionally, these caregivers and families suffered from substance abuse problems (18%), mental health problems (14%), criminal activity (13%), and spousal violence (10%).

Neglect. At least one caregiver functioning/family stressor issue was identified in three-quarters of the substantiated neglect cases (75%). Almost one-half of the caregivers of children with substantiated neglect suffered from substance abuse (47%). Other major concerns were noted as well, especially criminal activity (16%) and mental health problems (27%). History of child abuse (40%), lack of supports (39%), and spousal violence (23%) were also noted in substantiated cases of neglect.

Emotional Maltreatment. Of all the categories of maltreatment, substantiated cases of emotional maltreatment had the greatest number of associated caregiver and family problems: almost 9 out of 10 cases of emotional maltreatment (89%) had at least one caregiver functioning issue/family stressor. Most likely, these significant problems played a role in identifying the plight of the child (for example, the child was exposed to violence or substance abuse in the home). Notably, in over half (53%) of these cases substance abuse problems were identified, in over a third there were mental health problems, and in almost a quarter criminal activity was a concern.

Moreover, over two-thirds of the families (68%) experienced spousal violence (the reader should note that exposure to spousal violence was one of the identifying criteria for emotional maltreatment), and many had childhood histories of abuse. Not surprisingly, families' lack of support was noted in 1 in 3 families.

Summary

Fifty-one percent of substantiated cases of maltreatment involved boys, and 49% involved girls. In cases of physical abuse, a greater proportion of victims were boys (60%) than girls (40%), whereas in sexual abuse, 69% of the victims were girls and 31% boys. It is noteworthy that 4-7 year old boys accounted for about three times as many cases of sexual abuse as other age groups of boys. Boys and girls were about equally represented in cases of neglect and

emotional maltreatment. The highest proportion of neglect cases was among boys aged 0-3 years; the highest proportion of emotional maltreatment cases was in 4-7 year old girls.

In half of the substantiated cases of child maltreatment, there was at least one child functioning issue. Most of these concerns involved stress-related symptoms, such as depression or anxiety, as well as behavioural problems such as negative peer involvement, irregular school attendance and violence to others. These ratings were based on the initial intake investigation and did not capture behaviours that may have become a concern after the initial investigation.

The families of maltreated children were about 1.5 times as likely to be headed by a single parent as by two (biological)

parents. Whereas over half of the families derived their primary income from full- or part-time employment, another third was dependent on social assistance or some other form of benefit.

Although housing conditions were mostly described as safe, in more than 1 in 5 cases of maltreatment the child was considered to be living in unsafe conditions. In addition, about 1 in 4 cases involved children who had experienced one or more moves in the previous 6 months.

Coupled with stressful economic and housing arrangements, caregivers of maltreated children were described as having considerable adjustment problems across all categories of maltreatment. These problems included alcohol/drug abuse, mental health problems, a childhood history of abuse, and spousal violence.

4. COMMUNITY RESPONSES TO CHILD MALTREATMENT

This chapter describes community responses to child maltreatment, which include sources of maltreatment referrals, investigation outcomes, and referrals of children and family members to additional services. This information is critical for several reasons. Prevention and intervention with maltreating families require, at a minimum, community participation and awareness at all levels. All citizens share responsibility in ensuring the safety of children, and communities bear the burden of providing adequate services for reporting maltreatment as well as responding to the needs of identified families and children.

In addition, concern has been raised about under-reporting of suspicions of child maltreatment, suggesting that the mechanisms currently in place for identification may need to be supplemented.³⁷ Professionals' personal views on the use of physical punishment is one reason for under-reporting, since a belief in the use of physical discipline may influence the decision on whether to report suspicions of child maltreatment. In addition, the relative severity of injury may influence an individual's reporting decision, in that more

visible and severe injuries are more likely to be reported.

This chapter begins by discussing the sources of referral of children and families to child welfare agencies. Knowledge of referral sources provides important descriptive information about the ways that children who are suspected of being maltreated are identified by professional and non-professional members of the community.

Source of Referral/ Allegation

Professional/ Non-professional

The CIS recorded up to three separate sources of referral. Each independent contact with the child welfare agency or office regarding a child(ren) or family was counted as a separate referral. The person who actually contacted the child welfare agency/office was documented as the referral source. For example, if a child disclosed an incident of abuse to a school-teacher, who then told the school principal of the disclosure and the school principal made a report to child welfare services, only the principal was counted as the referral source. However, if both

the principal and the child's parent independently called, both would be counted as separate referral sources for one case.

The CIS Maltreatment Assessment Form included 18 pre-coded referral source categories and an open "other" category. These include the following:

Parent: This includes parents involved as a caregiver to the reported child, as well as non-custodial parents.

Child: A self-referral by any child identified as a subject of referral on the Intake Face Sheet.

Relative: Any relative of the child in question. Workers were asked to code "other" when a child was living with a foster parent, and a relative of the foster parent reported maltreatment.

Neighbour/Friend: This category included any neighbour or friend of the children, or of the family.

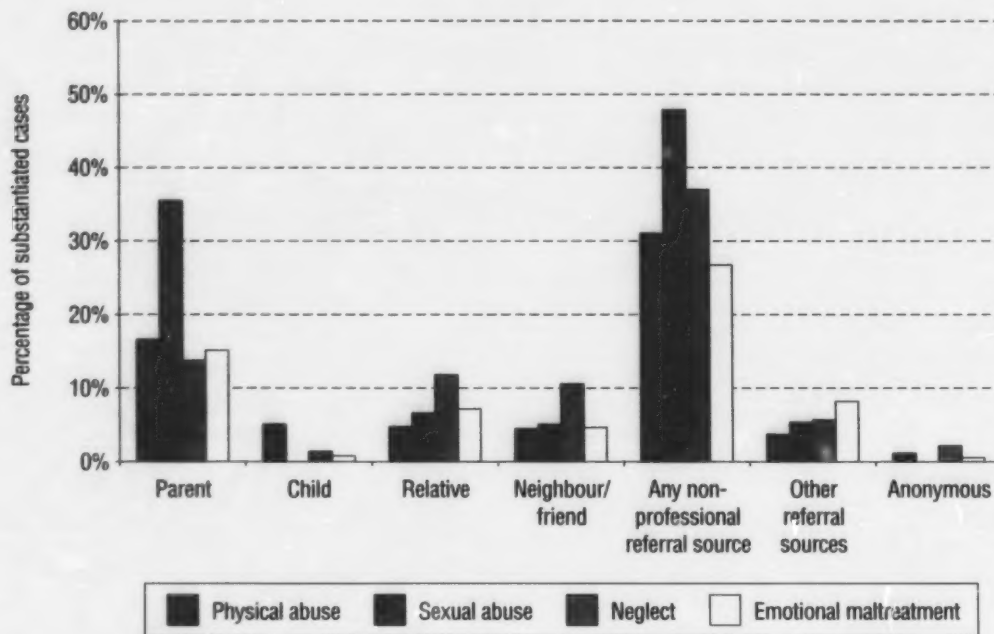
Anonymous: Any unidentified caller.

Police: Any member of police services, including municipal forces and the RCMP.

School Personnel: Any school personnel (teacher, principal, teacher's aide, school psychologist, etc.).

³⁷ Loo SK, Bala NMC, Clark ME, Hornick JP. *Child abuse: reporting and classification in health care settings*. Ottawa: Health Canada, 1998.

Figure 4-1(a)
Sources of Referral/Allegation (Non-Professional) by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table 8-1(a)

Health Professional: Included hospital- and clinic-based physicians and nurses, and public health nurses.

Mental Health Professional: Included family service agencies, mental health centres (other than hospital psychiatric wards), and private mental health practitioners (psychologists, social workers, other therapists) working outside of a school/hospital/child welfare/Young Offenders Act setting.

Other Child Welfare Service: Included referrals from mandated child welfare service providers from other jurisdictions or provinces.

Community Agency: Included agencies running any

form of recreation and community activity program (e.g. organized sports leagues, Boys and Girls Club); shelter or crisis service for family violence or homelessness; social assistance workers; child care or day care services; or any other community agency or service.

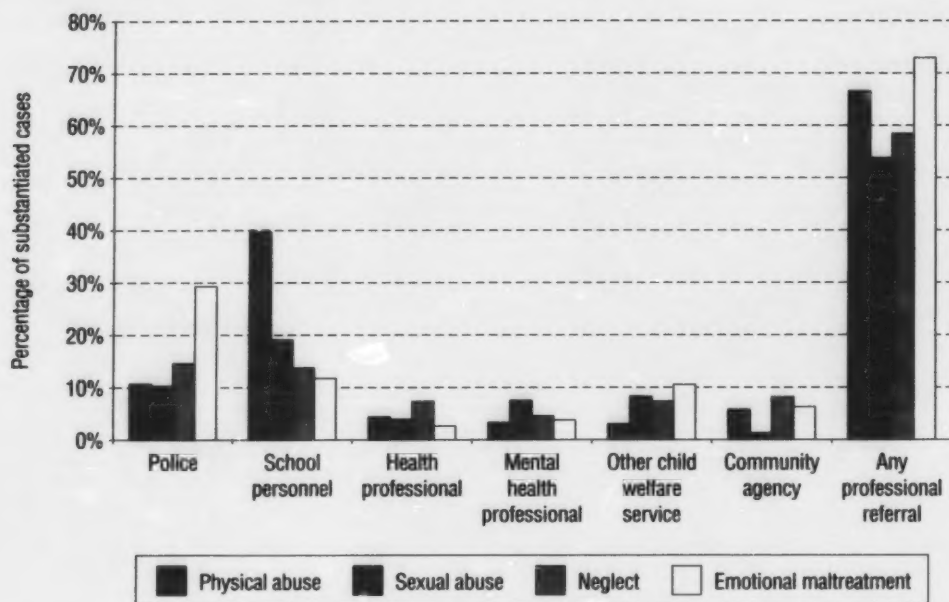
Other Referral Source: Any other source of referral.

Through their contact with children, professionals made almost two-thirds (64%) of all referrals of substantiated cases of child maltreatment (note that a child may be referred by more than one source, and the totals therefore do not add up to 100%). The two largest sources of professional referrals

were school personnel and the police, each of which referred about 1 in 5 of the substantiated cases (20% and 17% respectively). Non-professional sources referred about one-third (34%) of the total, with parents being the largest source of non-professional referral (17%), followed by relatives (8%) and neighbours or friends (7%).

A breakdown of professional and non-professional sources of referral or allegation by each primary category of substantiated child maltreatment is shown in Figures 4-1(a) and 4-1(b). With regard, first, to the non-professional sources of referral (Figure 4-1(a)),

Figure 4-1(b)
Sources of Referral/Allegation (Professional) by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table 8-1(b)

in general there is little differentiation in terms of category of maltreatment, with three notable exceptions. Children were more likely to report physical abuse than the other three categories of maltreatment. Another noteworthy pattern involves sexual abuse referrals. Compared with the other three categories of maltreatment, these children were much more likely to be referred by a parent (36%) or any non-professional source (48%). Finally, cases of child neglect stood out as being referred more often than the other categories by relatives (12%) or neighbours/friends (11%), which is consistent with the nature of this category of maltreatment.

With regard to professional sources of referral/allegation (Figure 4-1(b)), again the categories of maltreatment did not generally differ by source of referral. Two prominent exceptions, however, involve emotional maltreatment and physical abuse. Police were more likely to report emotional maltreatment (29%) than any other form. This finding most likely reflects the fact that police intervene in reports of domestic violence, and refer the children in the home to child welfare because of their exposure to such violence (a form of emotional maltreatment). School personnel, on the other hand, were much more likely (40%) to make referrals of child

physical abuse. Again, this finding reflects the nature of this form of abuse, whereby teachers (who come in contact with children each day) observe visible injuries or are told by children of their abuse.

Urban and Rural Referrals

As noted in Chapter 1, the CIS sampled investigations from 51 sites across Canada, which varied from rural sites covering large, sparsely populated areas to densely populated urban settings.

Mixed urban and rural child welfare services investigated close to half (44%) of the substantiated cases. The remaining cases were split equally between metropolitan

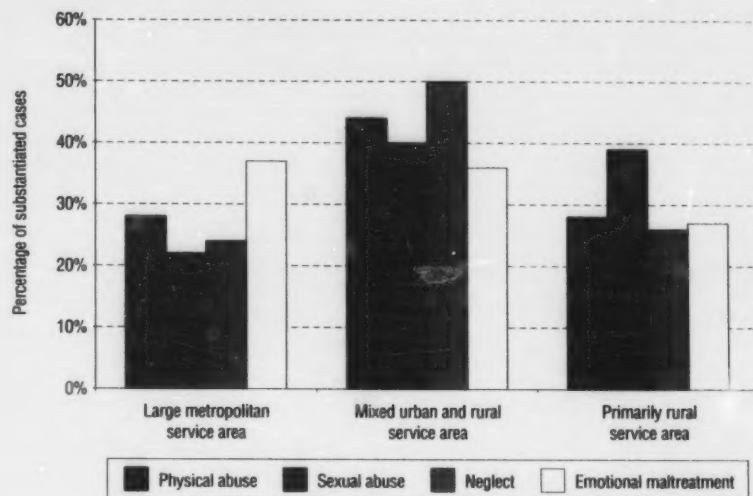
child welfare services (28%) and rural child welfare services (28%). As shown in Figure 4-2, the four categories of maltreatment did not differ widely in terms of urban and rural service areas.

Outcomes of Investigations

Child maltreatment prevention and intervention are assisted by consistent and coordinated community efforts, such as alternative care arrangements, coordinating committees to assist investigation, therapeutic services, training of personnel involved in child maltreatment, and involvement of the courts.

Five service outcomes were documented by the CIS Maltreatment Assessment Form: (1) provision of ongoing child welfare services; (2) referrals to other services; (3) placement of children in out-of-home care; (4) application to child welfare court; and (5) police involvement and criminal charges. The service outcome data presented in this chapter should be interpreted with caution, because they include only the case events that occurred during the investigation. Additional outcomes are likely to occur in cases kept open after the initial investigation.

Figure 4-2
Urban/Rural Location of Child Welfare Agencies, by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table B-6

Ongoing Child Welfare Services

Although child welfare services are available in every province, territory, and community, there is considerable variability in their community role and effectiveness. The CIS collected data to determine the nature and types of service most often used, such as foster homes, family therapy, child therapy, and others.

Investigating workers were asked whether the investigated case would remain open for ongoing child welfare services after the initial investigation. Workers completed these questions on the

basis of the information available at that time or at the completion of the intake investigation. It is important to understand that service outcomes might have differed if CIS information had been collected over an extended time frame.

At the completion of the initial investigation, 53% of substantiated child maltreatment investigations were identified as remaining open for ongoing services, and 45% were to be closed. Decisions were pending in the remaining 2% of substantiated cases because of court involvement, active police investigations, or incomplete assessments.

There was little differentiation across maltreatment categories in terms of cases remaining open or being closed, with the exception of child neglect. Physical abuse, sexual abuse, and emotional maltreatment cases remained open in about half of all substantiated investigations, whereas neglect cases were slightly more likely to remain open (60%). This latter finding may reflect the typically chronic nature of neglect, and the worker's opinion that such cases require ongoing services.

Out-of-home Placements

Although in most investigations (72%) the child did not require placement outside the home, in roughly 1 in 5 cases the child experienced a change in his or her living arrangements as a result of the investigation. These children either received an informal placement (7%) or were placed in foster care or other child welfare setting (15%).

For those children who did require out-of-home placements, foster care or other child welfare settings were almost twice as common for child neglect as for physical and sexual abuse. Emotional maltreatment was least likely to require an alternative placement (6%).

Child Welfare Court Involvement

Application to child welfare court can be made for an order of

supervision (child remaining in the home), temporary wardship (for a set time period), or permanent wardship. However, these terms vary by jurisdiction and may not apply in some circumstances. The CIS tracked the number of applications made or being considered during the initial investigation, but did not track the types of applications. Because applications may have been made at a point following the CIS data collection period, the CIS court involvement figures should be treated as underestimates of the true rate of court involvement. An application to court was considered (10%) or made (9%) for about 1 in 5 substantiated cases of child maltreatment. Such applications were considered or made most often for neglect (22%) and emotional maltreatment (21%), and less often for physical (17%) and sexual abuse (15%).

Police Involvement and Criminal Charges

There has been a growing emphasis on involving police in all situations that could lead to criminal charges, particularly in cases of child sexual abuse and child physical abuse. Detailed protocols between child welfare and police services specify the points during an investigation when police should be contacted, but these vary by jurisdiction. The CIS recorded whether a police investigation had been initiated during the child welfare investiga-

tion and, if so, whether criminal charges had been laid or were being considered. As with the other service outcomes described in this chapter, the CIS tracked only the events that occurred during the initial child welfare investigation; it is possible that police became involved in some cases after the CIS information forms had been completed. It should be further noted that the police also investigate many non-familial child maltreatment cases that do not involve child welfare services.

Police were involved in approximately 1 out of every 3 substantiated cases of child maltreatment. This involvement resulted in criminal charges being laid in about 1 in 5 cases, with another 11% investigated by police but not charged. As shown in Figure 4-3, sexual abuse was by far the most likely category of maltreatment to result in charges laid by police (70%). About one-quarter of emotional maltreatment cases and one-fifth of physical abuse cases also resulted in police charges. In contrast, charges were seldom laid in neglect cases (4%).

Referrals for Child and Family Services

The CIS tracked referrals made to programs designed to offer services beyond the parameters of "ongoing child welfare services". Workers were asked to indicate all applicable referral classifications identified for the family or child.

This included referrals made internally to a specialized program provided by a child welfare agency/office as well as referrals made externally to other agencies or services. A referral selection was meant to indicate whether a formal referral had been made, not whether the child or family had actually started to receive services. Fifteen referral categories were tracked:

Family Preservation/Reunification Program:

Family or home-based service designed to support families, reduce risk of out-of-home placement, or reunify children in care with their families (e.g. Family Preservation, Home Builders).

Parent Support Program:

Any group program designed to offer support or education (e.g. Parents Anonymous, parenting instruction course, Parent Support Association).

Other Family/Parent

Counseling: Programs for family therapy/counseling or couple counseling (e.g. family service bureau, mental health centre).

Drug/Alcohol Counseling:

Addiction programs (any substance) for caregiver(s).

Welfare/Social Assistance:

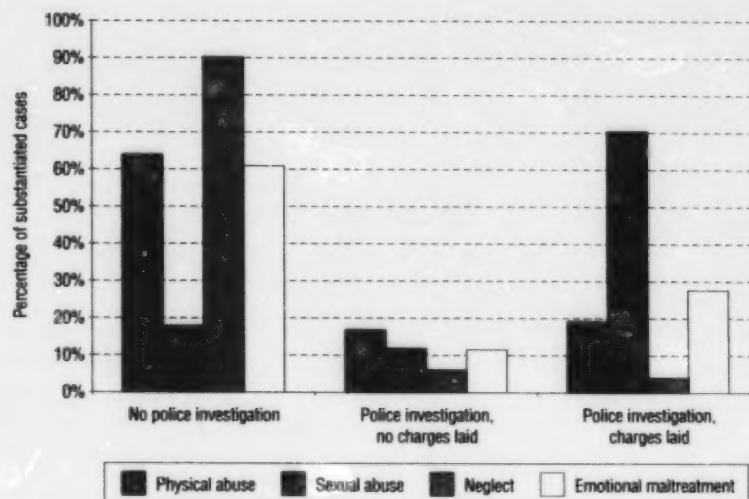
Referral for social assistance to address financial concerns of the household.

Food Bank: Referral to any food bank.

Shelter Services: Regarding family violence or homelessness.

Figure 4-3

Police Investigations and Charges Laid by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table 5-5

Domestic Violence

Counseling: Regarding domestic violence, abusive relationships, or the effects of witnessing violence.

Psychiatric/Psychological

Services: Child referral to psychological or psychiatric services (trauma, high-risk behaviour, or intervention).

Special Education Referral:

Any specialized school program to meet a child's educational, emotional, or behavioural needs.

Recreational Program:

Referral to a community recreational program (e.g. organized sports leagues, community recreation, Boys and Girls Club).

Victim Support Program:

Child-focused support program related to victim support.

Medical/Dental Services:

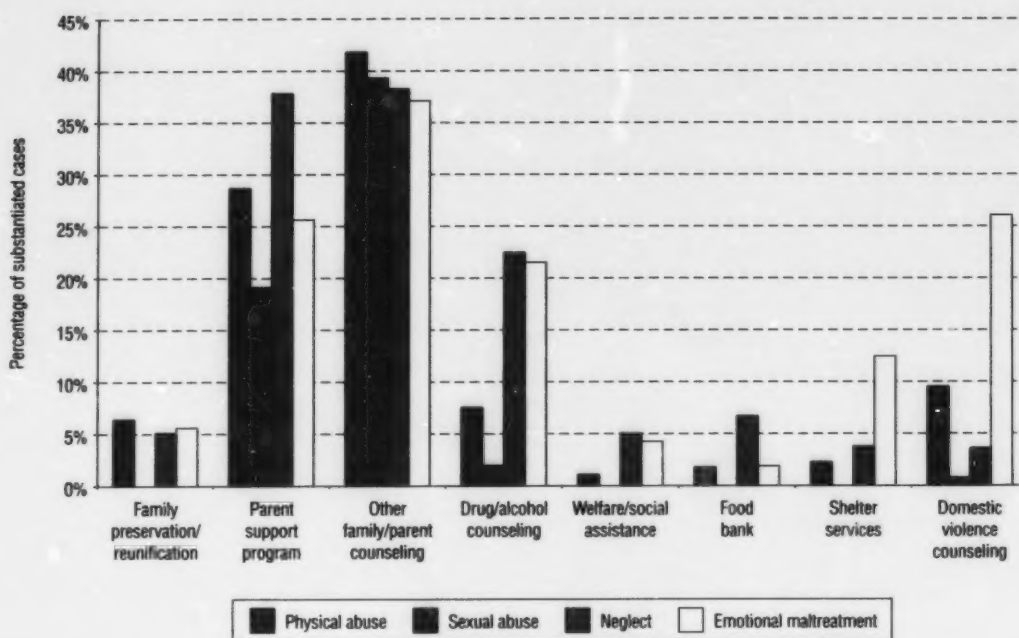
Any specialized service to address the child's immediate medical or dental health needs.

Other Child Counseling:

Any other child-focused counseling service (e.g. counseling centre, mental health centre, family service bureaus, drug or alcohol counseling).

Other Child/Family

Referral: Any other form of child- or family-focused referral.

Figure 4-4 (a)**Family-Focused Referrals to Other Services, by Primary Category of Substantiated Maltreatment**

Source: CIS Final Report, Table 5-2(a)

Referrals for services were relatively common, with over three-quarters (77%) of substantiated cases of child maltreatment receiving at least one child or family referral. Across all categories of maltreatment, the most common family-focused referrals were made to parent support programs (31%), counseling (39%), or drug/alcohol counseling (17%). Child-focused referrals most typically were made to psychiatric/psychological services (23%) or counseling (23%). Figures 4-4(a) and 4-4(b) show the distribution of family- and child-focused referrals according to each primary category of substantiated maltreatment.

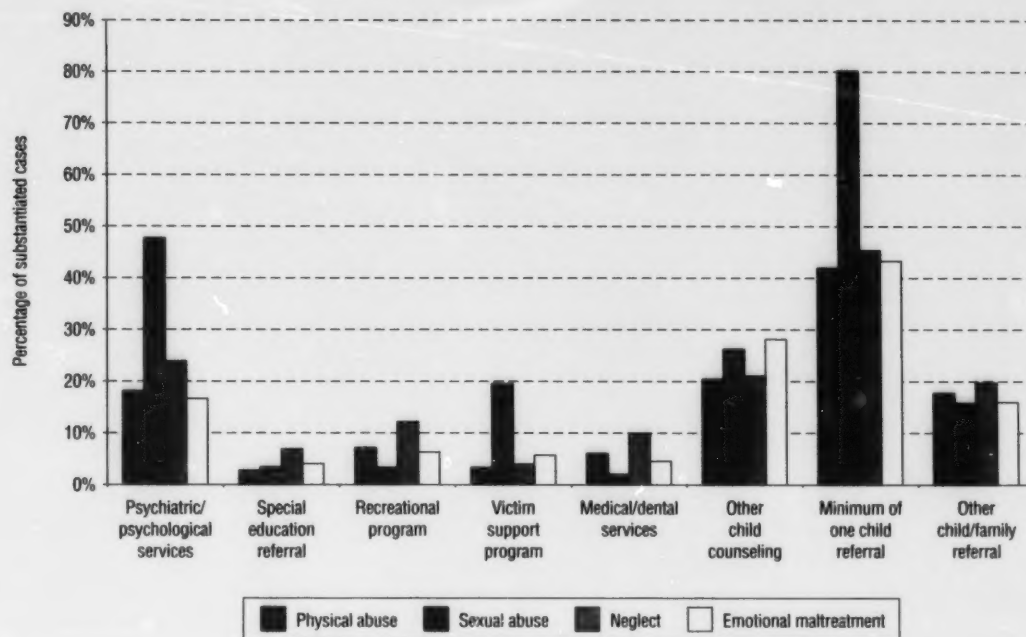
Physical Abuse. About 3 out of 4 (76%) substantiated cases of physical abuse received at least one child or family referral. As shown in Figure 4-4(a), family-focused referrals most often involved parent support programs and other family/parent counseling (over one-third of all cases), as well as drug/alcohol and domestic violence counseling (about 1 out of every 10 cases). In about 2 of every 5 cases of physical abuse, the child was referred to either psychiatric/psychological services or other child counseling (Figure 4-4(b)).

Sexual Abuse. The vast majority (90%) of substantiated

cases of child sexual abuse received at least one child or family referral. Figure 4-4(a) shows that family-focused referrals were most commonly made to parent support programs and other family/parent counseling, which may reflect the worker's choice to refer non-offending parents to community services as part of a comprehensive plan to assist the child. In addition, in 4 out of 5 cases of sexual abuse, there was at least one child-focused referral. About half of these children (48%) were referred for psychiatric/psychological services and 26% for other counseling. In 1 in 5 sexual abuse cases the child was referred to victim support

Figure 4-4 (b)

Child-Focused Referrals to Other Services, by Primary Category of Substantiated Maltreatment



Source: CIS Final Report, Table 5-2(b)

programs, which are offered in some communities to help abused children understand and cope with the court-related stressors associated with criminal charges.

Neglect. Like child physical abuse, about 3 out of 4 (74%) substantiated cases of neglect received at least one child or family referral. As shown in Figure 4-4(a), the most common family-focused referrals were for parent support programs (38%), other family/parent counseling (38%), and drug/alcohol counseling (22%). Neglected children received a broad range of referrals, which is consistent with the nature of child

neglect. These included referrals for psychiatric/psychological counseling (24%), other child counseling (21%), and recreational (12%) and medical/dental assistance (10%).

Emotional Maltreatment.

Similar to physical abuse and neglect, about 3 out of 4 (79%) substantiated cases of emotional maltreatment received at least one child or family referral. Again, family-focused referrals were most commonly made to parent support programs (26%), other family/parent counseling (37%), and drug/alcohol counseling (22%). In about 2 out of 5 cases (43%) of

emotional maltreatment there was at least one child-focused referral, most often made to psychiatric/psychological services (17%) or other child counseling (28%).

Summary

Maltreated children were referred to child welfare services from a wide variety of professional and non-professional sources. Two out of three substantiated cases of child maltreatment were referred by professionals in the community, who come into contact with children on a regular basis. In particular, school personnel and the police made many of these

"And for people who are doing these things and people who are the victims of these incidents, to make sure that they know there is help out there. There's always somebody that's willing to help. All they have to do is reach out their hand."

Participant in a youth focus group discussing prevention strategies.³⁸

referrals. The remaining third of the referrals came from non-professional community sources, such as parents, relatives, and neighbours or friends.

Physical abuse, sexual abuse, and emotional maltreatment cases remained open for ongoing service in about half of all substantiated investigations, whereas neglect cases were slightly more likely to remain open, reflecting the more chronic nature of this category of maltreatment.

Although most maltreated children did not require placement outside the home, in 1 in 5 cases the child experienced a change in living arrangements as a result of the investigation. These children either received an informal placement with relatives or neighbours or were placed in foster care or other child welfare setting.

In about 1 in 5 substantiated cases of child maltreatment, an application to court was considered or made. Court applications were slightly more common for substantiated neglect and emotional maltreatment than for physical and sexual abuse.

Police investigated about 1 out of every 3 substantiated cases of child maltreatment. Police investigations resulted in criminal charges being laid in about 1 in 5 cases, sexual abuse being the most likely to result in charges laid by police. It is important to emphasize that the CIS was only able to track police investigations that occurred during the initial child welfare investigation. Furthermore, police also investigate many non-familial child maltreatment cases that do not involve child welfare services.

Referrals to community agencies for ongoing services were relatively common, in that over three-quarters of substantiated cases of child maltreatment received at least one child or family referral. The most common family-focused referrals were to parent support programs, counseling, or drug/alcohol counseling. Child-focused referrals, which were most often related to sexual abuse, were typically made to psychiatric/psychological services or counseling.

³⁸ Charles G. *Youth focus group on child abuse and neglect*. Ottawa: Health Canada, unpublished report.

APPENDIX A

CIS Site Directors/Research Associates

CIS site directors were involved in designing the study and facilitating data collection in their respective sites. CIS research associates provided training and data collection support at the 51 CIS sites. Their enthusiasm and dedication to the study were critical in ensuring its success.

The following is a list of those who participated in the CIS.

British Columbia

Richard Sullivan (Site Director)
School of Social Work
University of British Columbia

Janet Douglas
Child Protection Services
Government of British Columbia

Prairies/North

Joe Hornick (Site Director)
Canadian Research Institute for Law and Family
University of Calgary

Avery Calhoun
Canadian Research Institute for Law and Family
University of Calgary

Ralph Bodor
Faculty of Social Work
University of Calgary

Ontario

Barbara Fallon (Project Manager)
Faculty of Social Work
University of Toronto

Julie Thompson
Faculty of Social Work
University of Toronto

Bruce MacLaurin (Project Manager)
Faculty of Social Work
University of Toronto

Warren Helfrich
Faculty of Social Work
University of Toronto

Sharon Bartholomew
Health Canada
Government of Canada

Nico Trocmé (Principal Investigator)
Faculty of Social Work
University of Toronto

Jairo Ortiz
Faculty of Social Work
University of Toronto

Quebec

Marc Tourigny (Site Director)

Département de psychoéducation et de psychologie
Université du Québec à Hull

Marie-Claude Larrivée

Université du Québec à Trois-Rivières

Micheline Mayer (Site Director)

Institut de recherche pour le développement
social des jeunes
Centres jeunesse de Montréal

Sonia Helie (EIQ Coordinator)

Institut de recherche pour le développement
social des jeunes
Centres jeunesse de Montréal

John Wright (Site Director)

Département de psychologie
Université de Montréal

Chantal Lavergne

Institut de recherche pour le développement
social des jeunes
Centres jeunesse de Montréal

Joanne Boucher

Partenariat de recherche et
d'intervention en matière d'abus
sexuel à l'endroit des enfants
Université de Montréal

Atlantic Provinces/Maritimes

Gale Burford (Site Director)

School of Social Work
Memorial University of Newfoundland

Julia Foran

Child Welfare Consultant
Fredericton, New Brunswick

Ken Barter (Site Director)

School of Social Work
Memorial University of Newfoundland

Brenda Romans

Family and Children Services of Yarmouth County
Yarmouth, Nova Scotia

Brian Kenny

Department of Health and Community Services
Government of Newfoundland and Labrador

Data Entry

Data entry of the CIS Face Sheet was completed by Cita de los Santos in Toronto. Data entry in Montreal was completed by Lydie Bouchard, Véronique Gauthier, Annie Bérubé, Mireille Desrochers, Bibiane Monfette, Nathalie Robertson, Caroline Gélinas.

Data Analysis

Assistance in developing the sampling design, custom area files, weights, and confidence intervals was provided by Statistics Canada. We would particularly like to thank Korina Besednik, Andrea Durning and Jane Mulvihill from Statistics Canada for their assistance.

Donald Morrison and Hong-Xing Wu are acknowledged for their statistical and technical support to the EIQ, specifically for data management and analysis.

Special thanks to Tim Daciuk, for his statistical support throughout the project.

APPENDIX B

National Advisory Committee and Health Canada Staff

The National Advisory Committee provided consultation for the design of the study, in particular with respect to the enlistment strategies and survey instruments. Health Canada staff played an active role throughout the study, providing feedback, consultation, and support at all phases of the project.

National Advisory Committee

Alberto Barceló

Regional Advisor for Non-Communicable Diseases
Pan American Health Organization
Washington, DC

Grant Charles

Partner
Garfat, Charles and Associates
Calgary, Alberta

Elizabeth Crawford

Director of Community Relations
Department of Health and Community Services
Government of Newfoundland and Labrador
St. John's, Nfld.

Ross Dawson

Director of Child Protection
Ministry of Children and Families
Government of British Columbia
Victoria, B.C.

Debbie Foxcroft

Executive Director
Nuu-chan-nulth
Community and Human Services
Port Alberni, B.C.

Cherry Kingsley

Consultant
Save the Children
Burnaby, B.C.

Harriet MacMillan

Centre for the Study of Children at Risk
Hamilton Health Sciences Corp.
Hamilton, Ont.

Peter Markesteyn

Consultant
University of Manitoba
Winnipeg, Man.

George Muswaggon

Awais Agency of Northern Manitoba
Cross Lake First Nations
Cross Lake, Man.

George Savoury

Director of Child Welfare
Family and Children's Services
Department of Community Services
Government of Nova Scotia
Halifax, N.S.

Sandra Scarth (Chairperson)

Child Welfare Consultant
Brentwood Bay, B.C.

Craig Shields

Consultant
Health and Social Services
Thornhill, Ont.

David Wolfe

Professor of Psychology
Department of Psychology
University of Western Ontario
London, Ont.

Health Canada Staff

Gordon Phaneuf

Chief, Child Maltreatment Division

Bureau of Reproductive and Child Health

Sharon Bartholomew

Richard De Marco

Janet Doherty

Amanda Harrington

Kim Kingsbury

Kathleen Moss

Lil Tonmyr

Lisa Wallans

Child Maltreatment Division

Bureau of Reproductive and Child Health

Ian McNeill

Consultant to Child Maltreatment Division

Bureau of Reproductive and Child Health

Catherine McCourt

Director, Bureau of Reproductive and Child Health

NOTES